

<i>SERFF Tracking Number:</i>	<i>EWLE-126902630</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Central United Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47310</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H111 Individual Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H111.004 Other</i>
<i>Product Name:</i>	<i>Disability Income</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## Filing at a Glance

Company: Central United Life Insurance Company

Product Name: Disability Income

SERFF Tr Num: EWLE-126902630 State: Arkansas

TOI: H111 Individual Health - Disability Income

SERFF Status: Closed-Approved-  
Closed

Sub-TOI: H111.004 Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Vicki Rowe

Disposition Date: 11/22/2010

Date Submitted: 11/12/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type:

Submission Type:

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 11/22/2010

Explanation for Other Group Market Type:

State Status Changed: 11/22/2010

Deemer Date:

Created By: Vicki Rowe

Submitted By: Vicki Rowe

Corresponding Filing Tracking Number:

Filing Description:

This filing is being submitted on behalf of Central United Life Insurance Company. The referenced forms are submitted for your review and approval. These forms are new and are not intended to replace any previously approved forms.

Form CDI10-AR is a Disability Income Policy; form CDI-APP10-AR is the Application; form CDI-SHQ10 is a Supplemental Health Questionnaire to the Application; form CUL-AAQ is an Aviation Activities and Hazardous Activities Questionnaire; form CDI-RAP10-AR is a Reinstatement Application; form CReqChg10 is the Policyholder's Request for Change; form CDI10-OC-AR is the policy's corresponding Outline of Coverage. The following are optional benefit riders: CDI-BBR10 - Building Benefit Rider; CDI-EAR10 - Emergency Accident Rider; CDI-OSR10 - Outpatient Sickness Rider; CDI-ADD10 - Accidental Death & Dismemberment Rider; CDI-HINJ10 - Hospital Injury Indemnity Rider; CDI-

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TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other  
Product Name: Disability Income  
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HIR10 - Hospital Indemnity Rider; CDI-SIR10 - Specified Injury Rider; CDI-HCR10 - First Hospital Confinement Rider.

The following forms are amendments/endorsements intended to provide routine revisions and/or corrections to the policy/application(s): CDI-AEND10 - Amendment/Endorsement and CDI-AENDS10 - Amendment/Endorsement with Signature.

## Company and Contact

### Filing Contact Information

Vicki Rowe, Compliance vrowe@lewisellis.com  
9441 LBJ Freeway 972-664-0163 [Phone]  
Suite 102  
Dallas, TX 75243

### Filing Company Information

(This filing was made by a third party - lewisandellisincorporated3)

Central United Life Insurance Company	CoCode: 61883	State of Domicile: Arkansas
10700 Northwest Freeway	Group Code:	Company Type:
Houston, TX 77092	Group Name:	State ID Number:
(713) 529-0045 ext. [Phone]	FEIN Number: 42-0884060	

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$900.00  
Retaliatory? No  
Fee Explanation: 17 forms 1 rate  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Central United Life Insurance Company	\$900.00	11/12/2010	41835115

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Product Name:	Disability Income		
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/22/2010	11/22/2010

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## Disposition

Disposition Date: 11/22/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Product Name: Disability Income  
Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Authorization to File	Approved-Closed	Yes
Form	Disability Income Policy	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Supplemental Health Questionnaire	Approved-Closed	Yes
Form	Aviation Activities and Hazardous Activities Questionnaire	Approved-Closed	Yes
Form	Reinstatement Application	Approved-Closed	Yes
Form	Policyholder's Request for Change	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Building Benefit Rider	Approved-Closed	Yes
Form	Emergency Accident Rider	Approved-Closed	Yes
Form	Outpatient Sickness Rider	Approved-Closed	Yes
Form	Accidental Death & Dismemberment Rider	Approved-Closed	Yes
Form	Hospital Injury Indemnity Rider	Approved-Closed	Yes
Form	Hospital Indemnity Rider	Approved-Closed	Yes
Form	Specified Injury Rider	Approved-Closed	Yes
Form	First Hospital Confinement Rider	Approved-Closed	Yes
Form	Amendment/Endorsement	Approved-Closed	Yes
Form	Amendment/Endorsement with Signature	Approved-Closed	Yes
Rate	Disability Income Policy, Building Benefit Rider, Emergency Accident Rider, Outpatient Sickness Rider, Accidental Death & Dismemberment Rider, Hospital Injury Indemnity Rider, Hospital Indemnity Rider, Specified Injury Rider, First Hospital Confinement Rider	Approved-Closed	Yes

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Company Tracking Number:

TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other

Product Name: Disability Income

Project Name/Number: /

## Form Schedule

### Lead Form Number: CDI10-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/22/2010	CDI10-AR	Policy/Cont ract/Fratern al Certificate	Disability Income	Initial			PolicyCDI10fi nal110310.pdf
Approved-Closed 11/22/2010	CDI- APP10-AR	Application/ Enrollment Form	Application	Initial			ApplicationCD I- APP10final.pd f
Approved-Closed 11/22/2010	CDI- SHQ10	Other	Supplemental Health Questionnaire	Initial			Supplemental HealthQuestio nnaireCDI- SHQ10final.p df
Approved-Closed 11/22/2010	CUL-AAQ	Other	Aviation Activities and Hazardous Activities Questionnaire	Initial			CUL-AAQ.pdf
Approved-Closed 11/22/2010	CDI- RAP10-AR	Application/ Enrollment Form	Reinstatement Application	Initial			Reinstatement ApplicationC DI- RAP10final.p df
Approved-Closed 11/22/2010	CReqChg1 0	Other	Policyholder's Request for Change	Initial			Policyholder's RequestforCh ange110310. pdf
Approved-Closed 11/22/2010	CDI10-OC- AR	Outline of Coverage	Outline of Coverage	Initial			CDI10-OC.pdf
Approved-Closed	CDI-BBR10	Other	Building Benefit Rider	Initial			BuildingBenef itRiderCDI-

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11/22/2010					BBR10final.p df
Approved- Closed 11/22/2010	CDI-EAR10Other		Emergency Accident Initial Rider		EmergencyAc cidentRiderC DI- EAR10fianl.p df
Approved- Closed 11/22/2010	CDI- OSR10	Other	Outpatient Sickness Initial Rider		OutpatientSic knessRiiderC DI- OSR10final.p df
Approved- Closed 11/22/2010	CDI-ADD10Other		Accidental Death & Initial Dismemberment Rider		AccidentalDe athandDisme mbermentRid erCDI- ADD10final.p df
Approved- Closed 11/22/2010	CDI- HINJ10	Other	Hospital Injury Initial Indemnity Rider		HospitalInjuryI ndemnityRide rCDI- HINJ10final.p df
Approved- Closed 11/22/2010	CDI-HIR10	Other	Hospital Indemnity Initial Rider		HospitalInde mnityRiderCD I- HIR10final.pdf
Approved- Closed 11/22/2010	CDI-SIR10	Other	Specified Injury RiderInitial		SpecifiedInjur yRiderCDI- SIR10final.pdf
Approved- Closed 11/22/2010	CDI- HCR10	Other	First Hospital Initial Confinement Rider		FirstHospitalC onfinementRi derCDI- HCR10final.p df
Approved- Closed 11/22/2010	CDI- AEND10	Other	Amendment/Endorse Initial ment		Amendmenta ndEndorseme ntCDI-

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<i>Project Name/Number:</i>	<i>/</i>		

Approved- CDI-	Other	Amendment/Endorse Initial
Closed AENDS10		ment with Signature
11/22/2010		

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**CENTRAL UNITED LIFE INSURANCE COMPANY**

*Home Office: [Little Rock, AR 72201]*

*Administrative Office:[ 10700 Northwest Freeway, Houston, TX 77092] [800-669-9030]*

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**DISABILITY INCOME POLICY**

**THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US. READ IT CAREFULLY.**

**GUARANTEED RENEWABLE TO AGE 70.  
SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS.**

**DISABILITY RESULTING FROM A PRE-EXISTING CONDITION WILL NOT BE COVERED IF IT BEGINS DURING  
THE FIRST 12 MONTHS AFTER THE POLICY EFFECTIVE DATE.**

**THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the guide to  
Health Insurance for People with Medicare, which is available from the Company.**

Important Cancellation Information – Please Read The Provision Entitled “Renewal Condition”, Found Below.

**RENEWAL CONDITION**

This Policy is guaranteed renewable to age 70 subject to the terms and conditions of this Policy. We have the right to change the premium rates on this Policy. See Change in Premium Rate section.

**INSURING CLAUSE**

We will pay Benefits set out in this Policy and any Rider(s) attached subject to its Definitions, Provisions, Limitations and Exclusions. This Policy is a legal contract between You and Us. Read it carefully. To understand Your coverage, You must read this Policy as a whole.

**THIRTY DAY RIGHT TO EXAMINE THIS POLICY**

If, for any reason, You decide not to keep this Policy, return it to Us within 30 days after You receive it. You may return it to Our Administrative Office or to the agent who sold it to You. We will treat the Policy as if it had never been issued. We will refund any Premium paid.



[Mary Lou Rainey  
Secretary]



[Dan George  
President]

**IMPORTANT NOTICE**

**PLEASE READ THE COPY OF THE APPLICATION ATTACHED TO THIS POLICY. IF ANY INFORMATION ON THE  
APPLICATION IS NOT TRUE AND COMPLETE, WRITE TO US AT OUR ADMINISTRATIVE OFFICE WITHIN 10  
DAYS. THE APPLICATION IS A PART OF THIS POLICY, WHICH WAS ISSUED ON THE BASIS THAT THE  
ANSWERS TO ALL QUESTIONS AND THE INFORMATION SHOWN ON THE APPLICATION ARE CORRECT AND  
COMPLETE.**

## INDEX

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## POLICY SCHEDULE

FORM: CDI10\*

PRIMARY INSURED: [JOHN A DOE]

INSURED DEPENDENTS: [ELIGIBLE SPOUSE  
ELIGIBLE DEPENDENT CHILDREN]

PRIMARY INSURED ISSUE AGE: [35]

POLICY NUMBER: [1234567]

POLICY EFFECTIVE DATE: [JANUARY 01, 2010]

FIRST ANNIVERSARY DATE: [JANUARY 01, 2011]

MODE SELECTED AT ISSUE: [ANNUAL/ PRD]

MODE PREMIUM: [\$2,223.48]

DESCRIPTION OF COVERAGE	BENEFIT AMOUNT	ANNUAL PREMIUM
<b>DISABILITY DUE TO AN INJURY FOR THE PRIMARY INSURED ONLY</b>		
ELIMINATION PERIOD	[0; 7; 14; 30; 60; 90; 180; 365] DAYS	
MAXIMUM BENEFIT PERIOD	[90 DAYS; 6 MONTHS; 1 YEAR; 2 YEARS]	
MONTHLY BENEFIT FOR DISABILITY	[\$200 to \$10,000 in increments of \$100]	[\$XX]
% OF REDUCTION OF MONTHLY BENEFIT WHEN BENEFIT REDUCTION APPLIES	[0%; 50%; 100%]	[\$XX]
<b>DISABILITY DUE TO A SICKNESS FOR THE PRIMARY INSURED ONLY</b>		
ELIMINATION PERIOD	[0; 7; 14; 30; 60; 90; 180; 365] DAYS	
MAXIMUM BENEFIT PERIOD	[90 DAYS; 6 MONTHS; 1 YEAR; 2 YEARS]	
MONTHLY BENEFIT FOR DISABILITY	[\$200 to \$10,000 in increments of \$100]	[\$XX]
% OF REDUCTION OF MONTHLY BENEFIT WHEN BENEFIT REDUCTION APPLIES	[0%; 50%; 100%]	[\$XX]
<b>FIRST HOSPITAL CONFINEMENT RIDER FORM CDI-HCR10*</b>		
Each Insured		[\$XX]
<b>EMERGENCY ACCIDENT RIDER FORM CDI-EAR10*</b>		
BENEFIT PER ACCIDENT FOR EACH INSURED Limited to 4 Accidents per Calendar Year	[\$50 to \$500 in increments of \$50]	[\$XX]

\* Or Appropriate State Edition

DESCRIPTION OF COVERAGE	BENEFIT AMOUNT	ANNUAL PREMIUM
<b>OUTPATIENT SICKNESS RIDER FORM CDI-OSR10*</b>		
BENEFIT PER SICKNESS FOR EACH INSURED Limited to 4 Sicknesses per Calendar Year	[\$25 to \$500 in increments of \$25]	[\$XX]
<b>ACCIDENTAL DEATH BENEFIT &amp; DISMEMBERMENT RIDER FORM CDI-ADD10*</b>		
Benefit Amount for Primary Insured	[\$1,000 to \$100,000 in increments of \$1,000]	[\$XX]
Benefit Amount for Eligible Spouse	[\$1,000 to \$25,000 in increments of \$1,000]	[\$XX]
Benefit Amount for each Eligible Dependent Child	[\$1,000 to \$10,000 in increments of \$1,000]	[\$XX]
<b>HOSPITAL INJURY INDEMNITY, RIDER FORM CDI-HINJ10*</b>		
Daily Benefit for Each Insured	[\$30 to \$500 per day [or Daily Hospital Indemnity Benefit amount whichever is less] in increments of \$10]	[\$XX]
<b>SPECIFIED INJURY BENEFIT, RIDER FORM CDI-SIR10*</b>		
Each Insured		[\$XX]
<b>BUILDING BENEFIT, RIDER FORM CDI-BBR10*</b>		
Primary Insured		[\$XX]
<b>HOSPITAL INDEMNITY, RIDER FORM CDI-HIR10*</b>		
Each Insured	[\$500 to \$10,000 in increments of \$100]	[\$XX]

\* Or Appropriate State Edition

## DEFINITIONS

### WHEN WE USE THE TERMS THAT FOLLOW, WE MEAN:

**Dental Treatment:** Treatment of the teeth and/or periodontal area.

**Dependent Child:** A financially dependent child, foster, stepchild or adopted child of the Primary Insured or any child placed with the Primary Insured that has filed a petition to adopt, named on the application, unless specifically excluded in any part of this Policy. Any newborn or child placed for adoption or whom the Primary Insured has filed a petition to adopt or foster care after the Policy Effective Date is considered a Dependent Child.

**Disability or Disabled:** Means Total Disability or Presumptive Disability.

**Eligible Dependent Child(ren):** Unless specifically excluded in any part of this Policy, means:

- a. Your unmarried Dependent Child under age 19 who is chiefly dependent on You for support and maintenance; or
- b. Your unmarried Dependent Child under age 23 if he/she is a full-time student at an accredited school, college, or university and We are furnished proof of such enrollment; or
- c. Your unmarried Dependent Child age 19 or over, who is chiefly dependent on You for support and maintenance if he/she is not able to support him/herself because of mental or physical incapacity. The burden of proof that such Dependent Child is and has continued to be incapacitated rests with You. You must give proof of the incapacity acceptable to Us at Our Administrative Office as asked for, but not more often than once a year.

**Eligible Spouse:** Your spouse You are legally married to who is listed on the application unless specifically excluded in any part of this Policy. Your spouse will cease to be an eligible spouse on the date of death or the day a valid decree of divorce is effective.

**Elimination Period:** The number of consecutive days of Total Disability before Benefits become payable under this Policy. Benefits are not payable during the Elimination Period. The Elimination Period is shown on the Policy Schedule.

If the Elimination Period is 30 days or greater (does not apply if the Elimination Period is less than 30 days), it will be considered continuous if the Insured returns to work for not more than a total of 4 days during the Elimination Period. The Elimination Period will be extended by one day for each day the Insured temporarily returns to work.

**Employed:** You will be classified as employed if You are actively:

- a. performing for pay in the usual manner the duties of Your Regular Occupation on a scheduled work day; and
- b. performing these duties at one of the places of business where you normally do such duties or at some location to which Your employment sends You.

You will be said to be employed on a day that is not a scheduled work day only if You would be able to perform in the usual manner the duties of Your Regular Occupation if it were a scheduled work day.

If You are on a family or medical leave of absence, You will be considered employed if:

- a. Premiums are paid in accordance with the Policy provisions; and
- b. Your employer has approved Your leave in writing.

The period of time that You will be considered employed under a family or medical leave is the greater of:

- a. the leave period required by the Federal Family and Medical Leave Act of 1993, and any Amendments; or
- b. the leave period required by applicable State law.

**Full-Time:** 27 or more hours per week.

**Hospital:** A lawfully operating institution which:

- a. has resident facilities for sick and injured patients; and
- b. mainly provides diagnostic, medical and surgical treatment for a fee to sick or injured persons (or has such treatment facility available on a prearranged, contractual basis); and
- c. has 24 hour nursing service by or under the supervision of a graduate registered nurse; and
- d. has at least one Physician on the staff who is on call at any time; and
- e. is accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association, subject to the limitations in the paragraph below.

A hospital is not an institution or part of an institution that mainly provides rehabilitation, custodial, convalescent, nursing, extended or rest care.

**Hospital Confinement:** Admission to a Hospital and confinement as a resident bed patient due to an Injury or Sickness for which there is a room and board charge by the Hospital. The confinement must be on the advice of a Physician and be Medically Necessary. Confinement to an emergency room, outpatient treatment room, or observation unit for 48 hours or less is not considered a hospital confinement unless You remain in the emergency room, outpatient treatment room or observation unit until admission to the same Hospital as a resident bed patient.

**Insured:** The Primary Insured and any Insured Dependents shown on the Policy Schedule.

**Insured Dependents:** The Insured Dependents shown on the Policy Schedule.

**Injury/Injured:** Bodily injury sustained which:

- a. is directly caused by an accident, independent and unrelated of all other causes; and
- b. has not been specifically excluded by name or description in this Policy; and
- c. is not caused or contributed to by Sickness; and
- d. occurs while this Policy is in force for You.

**Material and Substantial Duties:** Those duties normally required for the performance of Your Regular Occupation that cannot be reasonably omitted or modified.

**Maximum Benefit Period:** The longest period of time during which the Benefit could be payable. The Maximum Benefit Period is shown on the Policy Schedule.

**Medically Necessary:** The treatment, services or supplies necessary and appropriate for the diagnosis or treatment of Sickness or Injury based upon generally accepted medical standards.

**Mental or Nervous Disorders:** A neurosis, psychoneurosis, psychosis or mental or emotional disease/disorder of any kind.

**Monthly Base Earnings:** Your monthly rate of earnings from Your employer in effect immediately prior to the date Total Disability begins. Overtime pay, bonuses, shift differential, expenses, allowances, and other fringe benefits or extra compensation You received or may be eligible to receive from Your employer are not included. Commissioned employee's earnings will be the average of the earnings for the lesser of: 1) the preceding 24 months; or 2) the total time You have been employed with Your employer.

**Other Income:** Loss of income or disability benefits You receive or are eligible to receive that are provided under any: 1) State compulsory benefit act or law; 2) Workers' Compensation Law; 3) occupational disease law; or 4) Federal Social Security Disability law; or 5) other act or law with similar intent.

**Part Time:** Less than 27 hours per week.

**Partially Disabled or Partial Disability:** Partial Disability must be due to a covered Injury or a covered Sickness. You are partially disabled if You:

- a. are able to perform at least one, but not all, of the Material and Substantial Duties of Your Regular Occupation or any other occupation on a Full-Time or Part-Time basis; or
- b. are able to perform all the Material and Substantial Duties of Your Regular Occupation or any other occupation on a Part-Time basis.

You must be under the Regular Care of a Physician. This does not apply if the Physician tells Us and We agree that Regular Care would be of no further benefit to You.

**Physician:** A person who:

- a. is operating within the scope of his/her license; and either
- b. is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- c. is legally qualified as a medical practitioner and required to be recognized, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

A physician does not include a family member of the Insured. Family member means You, Your spouse, children, grandchildren, siblings, parents, grandparents, corresponding in-laws, or other members of Your household.

**Policy:** The legal contract between You and Us. This Policy, any application(s), the Policy Schedule(s) and any attached Riders, Amendments, or Endorsements make up the entire contract between You and Us.

**Policy Anniversary:** The yearly anniversary of the Policy Effective Date. The First Anniversary Date is shown on the Policy Schedule.

**Policy Effective Date:** This is the date coverage under this Policy begins. The Policy Effective Date is shown on the Policy Schedule. It will be used to determine Premium due dates and anniversary dates. If an Insured is added to this Policy after the date listed on the Policy Schedule, the Policy Effective Date for that Insured will be the date shown on the Endorsement added to this Policy.

**Policy Schedule:** This is page 3 of this Policy.

**Presumptive Disability:** Presumptive Disability must be due to a covered Injury or a covered Sickness. You have a Presumptive Disability if You suffer the total, permanent and irrecoverable loss of:

- a. speech; or
- b. hearing in both ears; or
- c. the sight of both eyes; or
- d. the use of both hands, or both feet or one hand and one foot.

You must be Employed when Presumptive Disability begins. Benefits for Presumptive Disability will not be paid if You are not Employed when the Disability begins. The ability to work will not matter. You are not required to be under the Regular Care of a Physician. Proof of Presumptive Disability will be required.

**Primary Insured:** The Primary Insured as indicated on the Policy Schedule.

**Recurrent Disability:** You become Disabled, cease from being Totally Disabled, then become Totally Disabled again from the same or related condition. The latter Disability will be considered a Recurrent Disability. Refer to the "When a Recurrent Disability Becomes a New Disability" provision of this Policy.

**Regular Care:** You personally visit a Physician whose specialty or experience is the most appropriate to evaluate, manage or treat Your Injury or Sickness. The care and treatment You receive must be as frequent as is Medically Necessary.

**Regular Occupation:** The occupation You are routinely performing when Disability begins. We will look at the occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

**Sickness:** Disease or illness, including pregnancy, which: (1) is diagnosed or treated while this Policy is in force for the Insured; and (2) does not result from Pre-existing Conditions as defined; and (3) has not been specifically excluded by name or description in this Policy.

**Totally Disabled or Total Disability:** Total Disability must be due to a covered Injury or covered Sickness. You are Totally Disabled when You are: 1) unable to perform the Material and Substantial Duties of Your Regular Occupation during the Elimination Period and the following 2 years; thereafter, it means Your inability to perform the duties of any occupation for which You are reasonably suited by education, training or experience; and 2) not performing any work or services for pay.

You must be Employed when Total Disability begins. Benefits for Total Disability will not be paid if You are not Employed when Total Disability begins.

Proof of Total Disability will be required. You must be under the Regular Care of a Physician. This does not apply if the Physician tells Us and We agree that Regular Care would be of no further benefit to You.

**We, Our, the Company and Us:** refers to the Company as indicated on the cover of this Policy.

**You, Your and Yours:** The Primary Insured as indicated on the Policy Schedule.

## GENERAL AGREEMENT

**We agreed to issue this Policy to You because:**

- a. You paid the first Premium; and
- b. We relied on the answers in Your application.

Your application is attached and is a part of Your Policy. This Policy is a legal contract between You and Us.

This Policy covers only You. The Riders cover You and the Insured Dependents. The Riders, if any, also cover any person added as an Insured after the Policy Effective Date. Any changes to this Policy will be shown by an amendment, endorsement or Rider to be attached to this Policy.

The first Policy term begins at 12:00 P.M. Standard Time on the Policy Effective Date at the place You live. It ends at 12:00 P.M. Standard Time at the place You live on the Policy Anniversary. You may then renew this Policy for the next term by paying Premiums when due. The renewal Premium for each term is due on the day the preceding term ends subject to the Grace Period.

## PREMIUMS

All Premium due dates are determined from the Policy Effective Date.

Premiums for this Policy are due in advance of the term they are to cover.

You may pay Premiums on any mode acceptable to Us. This Policy will remain in force for the term for which Premiums are paid.

**Change in Premium Rate:** We have the right to change Premiums at any time. When this occurs, the new rate will be guaranteed for a period of not less than 12 months. If We do change the Premiums, We will do so only:

- a. if We change the Premiums for all policies of this same form and issue age in Your state of issue; and
- b. if such change is in accordance with the laws and regulations of Your state of issue; and
- c. if We give You 45 days notice before such change becomes effective.

Any change in the Premium will be based on Your age and occupation class as of the Policy Effective Date.

**Refund of Unearned Premium:** Within 30 days of proof of death or cancellation of this Policy, We will refund any unearned Premium. Unearned Premium is any Premium paid for any period beyond the date death or cancellation occurred.



## **BENEFITS**

The following are shown on the Policy Schedule:

- a. the Elimination Period for Disability due to: 1) an Injury; or 2) a Sickness; and
- b. the Maximum Benefit Period for a Disability (may differ at age 65) due to: 1) an Injury; or 2) a Sickness; and
- c. the Monthly Benefit for Disability due to: 1) an Injury; or 2) a Sickness; and
- d. the percentage of reduction of Monthly Benefit when Benefit Reduction Applies due to an Injury or Sickness.

### **Injury Disability Benefit**

We will pay the Monthly Benefit for Disability (subject to the Benefit Reduction section) due to an Injury if:

- a. Total Disability due to an Injury continues beyond the Elimination Period (the Elimination Period does not apply to a Presumptive Disability); and
- b. the Injury: 1) occurred after the Policy Effective Date; and 2) occurred while this Policy was in force; and 3) was not subject to the Pre-Existing Conditions provision; and 4) has not been specifically excluded by name or description in this Policy; and
- c. You lose income due to such Total Disability.

If Disability begins more than 60 days after an Injury, Disability will be considered to be the result of a Sickness. The Injury must occur while this Policy is in force.

Benefits will be payable until the earliest of the following:

- a. the date You cease to be Totally Disabled (does not apply to a Presumptive Disability); or
- b. the date You fail to provide satisfactory proof of continued Total Disability when requested; or
- c. the date You are outside of the United States, its possessions, or Canada (does not apply to a Presumptive Disability); or
- d. the date the Maximum Benefit Period ends; or
- e. the date You die.

We will only pay up to the applicable Maximum Benefit Period for any one Disability. The Maximum Benefit Period At Age 65 may differ.

### **Sickness Disability Benefit**

We will pay the Monthly Benefit for Disability (subject to the Benefit Reduction section) due to a Sickness if:

- a. Total Disability due to a Sickness continues beyond the Elimination Period (the Elimination Period does not apply to a Presumptive Disability); and
- b. the Sickness: 1) begins after the Policy Effective Date; and 2) begins while this Policy is in force; and 3) was not subject to the Pre-Existing Conditions provision; and 4) has not been specifically excluded by name or description in this Policy; and
- c. You lose income due to such Total Disability.

If Disability begins more than 60 days after an Injury, Disability will be considered to be the result of a Sickness. The Injury must occur while this Policy is in force.

Benefits will be payable until the earliest of the following:

- a. the date You cease to be Totally Disabled (does not apply to a Presumptive Disability); or
- b. the date You fail to provide satisfactory proof of continued Total Disability when requested; or
- c. the date You are outside of the United States, its possessions, or Canada (does not apply to a Presumptive Disability); or
- d. the date the Maximum Benefit Period ends; or
- e. the date You die.

We will only pay up to the applicable Maximum Benefit Period for any one Disability. The Maximum Benefit Period At Age 65 may differ.

## **Benefit Reduction**

Your Benefit may differ if You receive or are eligible to receive any Other Income. Other Income must be for the same period You are entitled to a Monthly Benefit for Disability due to an Injury or Sickness. The percentage that the Monthly Benefit will reduce in such case is shown on the Policy Schedule.

We have the right to require reasonable proof of Other Income You receive or are eligible to receive during any month of Disability. We have the right to recover from You any amount of Benefits overpaid as a result of a retroactive award of Other Income Benefits.

## **Partial Disability Benefit**

We will pay a Partial Disability Benefit if:

- a. You have received Total Disability Benefits under this Policy for at least 2 consecutive months; and
- b. You are Partially Disabled the day following the date Total Disability ended; and
- c. Partial Disability is the result of the same Injury or Sickness which caused the Total Disability; and
- d. Your earnings are not greater than 80% of Your Monthly Base Earnings.

The Partial Disability Benefit will be the lesser of: 1) 50% of the Monthly Benefit for Disability that You were eligible to receive during the prior month before Partial Disability began; or 2) the difference between Your current earnings and Your Monthly Base Earnings. The Partial Disability Benefit will be payable for a maximum period of 3 months. The combined period of time Benefits are payable for Total Disability and Partial Disability will not exceed the Maximum Benefit Period. The Maximum Benefit Period At Age 65 may differ.

The Partial Disability Benefit will be paid until the earliest of:

- a. the date You cease to be Partially Disabled; or
- b. the date You fail to provide satisfactory proof of continued Partial Disability when requested; or
- c. the date You are outside of the United States, its possessions, or Canada (Limitations & Exclusions); or
- d. the date the Maximum Benefit Period ends; or
- e. 3 months; or
- f. the date Your earnings are greater than 80% of Your Monthly Base Earnings; or
- g. the date you die.

We can require that You send Us appropriate financial records to prove Your income during the time You are Partially Disabled.

## **Maximum Benefit Period At Age 65**

The Maximum Benefit Period for any new Disability that begins after age 65 will be the lesser of Your current Maximum Benefit Period or 12 months.

## **Total, Presumptive or Partial Disability Benefit for Part of a Month**

If a Benefit is payable for less than a full month, We will pay one-thirtieth of the applicable Benefit for each day of Total, Presumptive or Partial Disability.

## **When a Recurrent Disability Becomes a New Disability**

A Recurrent Disability will be treated as the same Disability unless the requirements of the paragraph below are met. This means the Elimination Period and Maximum Benefit Period for Disability in this Policy will not start over. Any Recurrent Disability caused by a Pre-Existing Condition will be treated as the same Disability.

The only time a Recurrent Disability is treated as a new Total Disability is if You have returned to work for six months or more. During this time, You must have been working the lesser of: 1) the same number of hours You were working before the first Total Disability for the same or related condition; or 2) Full-Time. The Elimination Period and Maximum Benefit Period will start over for a new Total Disability.

A Recurrent Disability caused by a Presumptive Disability will never be classified as a new Disability. It will always be considered as the same Disability even if the requirements of the above paragraph are met.

### **Concurrent Disability**

We will pay Benefits for only one Disability at a time even if it results from more than one cause. If Disability results from more than one cause, it will be considered the same Disability. You will be entitled to only one Benefit.

### **Survivor Benefit**

If You die while receiving Disability Benefits for at least 6 consecutive months, We will pay a Survivor Benefit. The Survivor Benefit will be a lump sum of 6 times the Disability Benefit You are eligible for the calendar month before death. The Survivor Benefit will be paid to Your designated beneficiary or to Your estate if a beneficiary is not named.

### **Waiver of Premiums**

After You have received Benefits for Total or Presumptive Disability for 90 consecutive days. Starting the 91<sup>st</sup> day or the next due date, We will waive future Premiums. We will waive the Premium as long as You are receiving Benefits for Total, Presumptive or Partial Disability. However, We will not waive Premiums beyond the Maximum Benefit Period.

## **LIMITATIONS & EXCLUSIONS**

### **PART I**

This Policy (including any Rider(s) attached) does not cover losses sustained while caused by, contributed to or resulting from:

- a. being legally intoxicated as defined by State law where the loss occurred or being under the influence of any narcotic unless administered on the advice of a Physician; or
- b. alcoholism or drug addiction or Sickness or Injury from the use of alcohol and/or the use of drugs not prescribed by a Physician; or
- c. attempted suicide while sane or insane or intentionally self-inflicted Injury; or
- d. Mental or Nervous Disorders; or
- e. being exposed to war or any act of war, declared or undeclared or while serving in the armed forces; or
- f. engaging in an illegal activity; or
- g. participation in any form of aviation other than as a fare-paying passenger in a fully licensed passenger carrying aircraft; or
- h. voluntary inhalation of gas; or
- i. mountaineering, sky diving, hang gliding or bungee jumping; or
- j. riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
- k. conditions specifically excluded by Amendment or Endorsement; or
- l. any Pre-Existing Conditions as defined in this Policy.

### **PART II**

This Policy (including any Rider(s) attached) does not pay Benefits for:

- a. care that is primarily for: 1) rest; or 2) convalescence; or 3) rehabilitation; or
- b. treatment which is rendered outside the United States, its possessions, or Canada, except for emergency care for acute onset of Sickness or Injury sustained while traveling for business or pleasure; or
- c. Total or Partial Disability while You are outside of the United States, its possessions, or Canada; or
- d. Dental Treatment or plastic surgery for cosmetic purposes. This exclusion does not apply if the treatment or surgery is: 1) due to an Injury; or 2) to restore normal bodily functions; or
- e. Total or Presumptive Disability that begins while not Employed.

We will not pay Benefits for any period the Insured is incarcerated in any type of penal institution.

## **PRE-EXISTING CONDITIONS**

This Policy and any attached Rider(s) do not cover Pre-Existing Conditions whether disclosed in the application or not, for any loss that occurs during the first 12 months beginning on the date that person becomes an Insured under this Policy or Rider. Any Disability resulting from a Pre-Existing Condition will not be covered if it begins during the first 12 months after the Policy Effective Date. Refer to When a Recurrent Disability Becomes a New Disability section for a Recurrent Disability from a Pre-Existing Condition.

By Pre-Existing Conditions, We mean a condition for which a Physician prescribed, recommended or gave to the Insured during the 12 months before the Insured's Policy/Rider Effective Date: 1) treatment; or 2) medical advice; or 3) consultation; or 4) diagnosis or diagnostic tests; or 5) medication.

For any person who was age 65 and over when they become an Insured under this Policy, Pre-Existing Conditions shall mean only those conditions specifically excluded in any part of this contract or attached endorsement.

Conditions specifically named or described as excluded in any part of this Policy are never covered.

## **MILITARY SERVICE**

If You enter full time, active duty in the military service, You may suspend this Policy. However, You may not suspend this Policy during active military duty or training lasting three months or less. This Policy will not be in force while it is suspended and You will not have to pay any Premiums. We need Your written request to suspend this Policy. We will refund the pro-rata portion of any Premium paid for a period beyond the date We receive Your request.

If Your full time active duty in military service ends before Your 65<sup>th</sup> birthday, You may place this Policy back in force without evidence of insurability. Your coverage will start again when:

- a. We receive Your written request; and
- b. You have paid the pro-rata Premium for coverage until the next Premium due date.

We must receive Your request and Premium payment within 90 days after the date Your active duty service in the military ends. Premiums will be at the same rate they would have been had Your Policy remained in force. This Policy will not cover any loss due to Injury or Sickness that occurs while this Policy is suspended. In all other respects, You and We will have the same rights under this Policy as before it was suspended.

If Your active duty ends after Your 65<sup>th</sup> birthday, this Policy cannot be reinstated.

## **TERMINATION**

This Policy will end on the earliest of:

- a. the date You fail to pay Premiums within Your Grace Period; or
- b. the date You die; or
- c. the Policy Anniversary Date after You turn age 70; or
- d. the date You notify Us in writing to end this Policy.

All coverage under this Policy and any attached Rider(s) will terminate when this Policy ceases to be in force.

Coverage for an Insured Dependent will end on the date such Insured ceases to be an Eligible Dependent Child or Eligible Spouse.

When an Insured Dependent's coverage ends, We will:

- a. refund any Premium accepted for the period the Insured is not eligible; and
- b. consider any claim that began before the insurance ended; and
- c. allow a conversion policy as set forth in the Conversion Privilege provision of this Policy.

## ELIGIBILITY AND ADDITION OF PERSONS

**THE DISABILITY INCOME COVERAGE IS FOR THE PRIMARY INSURED ONLY.** Your Insured Dependents are only covered under any Riders attached to this Policy other than the building Benefit Rider (if elected). Your spouse and any children who qualify as an Eligible Dependent Child or Eligible Spouse may be added to the Riders attached to this Policy. To add a person (other than a newborn, foster or adopted child) to this Policy after the Policy Effective Date, You must:

- a. make written application to Us; and
- b. furnish proof that the person is insurable by Our underwriting standards; and
- c. pay the additional Premium due for that person. The first Premium for the person to be added will be determined from the effective date of his/her coverage. The person added will be subject to the Pre-Existing Conditions provision of this Policy commencing as of their coverage effective date.

Any child born to You while this Policy is in force will be automatically insured from the moment of birth for 90 days. A child placed with You for adoption or whom You filed a petition to adopt after the Policy Effective Date will be covered for a period of 60 days from the earlier of: (1) the date you file a petition for adoption; or (2) birth if the adopted child is a newborn. A child placed with You as a foster child shall automatically be covered for a period of 60 days from the date of placement. Coverage and Benefits for the child on the Riders will be the same as those that are provided for Eligible Dependent Children; if none, then Eligible Spouse. If there are no other Insured Dependents, then the coverage and Benefits on the Riders for the child will be the same as for You.

The Pre-Existing Conditions provision of this Policy is waived for the newborn, foster or adopted child. Coverage for a child placed for the purpose of adoption will end if the adoption is stopped prior to legal adoption.

**Without Eligible Dependent Children coverage:** To continue coverage for the newborn, foster or adopted child beyond the insured period, You must: (1) notify Us in writing; and (2) pay the Premium for the child within: (a) 90 days from the date of birth for a child born to You (b) for an adopted child, 60 days from the date You file a petition for adoption or the date of birth; or (c) 31 days from the date of placement of a foster child. Premiums for the child will be prorated to the next Premium due date of this Policy. If We are not notified and the required Premium is not paid within such time, the coverage for the child will terminate at the end of the time periods shown above.

**With Eligible Dependent Children coverage:** Please notify Us in writing as soon as possible to be sure that the child is properly enrolled, and coverage is in place. A newborn child will be covered from the moment of birth. A foster child will be covered from the moment of placement. An adopted child will be covered from the earlier of: (1) the date You file a petition for adoption; or (2) birth if the adoptive child is a newborn.

## CONVERSION PRIVILEGE

**When a Dependent Child ceases to be an Eligible Dependent Child,** coverage can be converted to a new policy. We must receive a written application and the required Premium within 31 days after the date their coverage is to end. The new policy will:

- a. be issued without evidence of insurability; and
- b. be a policy form We offer; and
- c. be most similar to but not greater than the Eligible Dependent Child's coverage in this Policy; and
- d. exclude any conditions that were excluded in this Policy for such Insured; and
- e. cover Pre-Existing Conditions to the extent they are covered in this Policy.

Coverage under the new policy will begin on the next day after the date coverage for the Eligible Dependent Child ended under this Policy. The Premium will be based on the table of rates in effect for the person's age and state of residence at the time of conversion.

**If You Die or if You and Your Eligible Spouse become Divorced,** Your Eligible Spouse may convert their existing coverage to a new policy. Written application for the policy must be made to Us within 60 days of Your death or entry of the order of divorce. The required Premium must be paid within 60 days after the date this coverage is to end. The new policy will:

- a. be issued without evidence of insurability; and
- b. be a policy form We offer for conversion; and
- c. be not greater than the Eligible Spouse's coverage in this Policy; and
- d. exclude any conditions that were excluded in this Policy for such Insured; and
- e. cover Pre-Existing Conditions to the extent they are covered in this Policy.

Coverage under the new policy will begin on the next day after the date coverage for the Eligible Spouse ended under this Policy. The Premium will be based on the rates in effect for that person's age and state of residence at the time of conversion.

At the option of the Eligible Spouse, any Eligible Dependent Children covered under this Policy (for whom the Eligible Spouse has the obligation of support) may also be converted to the new policy. Said conversion is subject to the same conditions as the Eligible Spouse's conversion.

### **GENERAL PROVISIONS**

**Cancellation by the Insured:** You may cancel this Policy at any time by giving written notice to the Company. We will cancel this Policy upon receipt of such notice or on a later date if specified in the notice. The Company will return any Unearned Premium paid. The Unearned Premium will be computed on a pro-rata basis. Cancellation will be without prejudice to any claim that began prior to the effective date of cancellation.

**Change of Beneficiary:** You may change Your beneficiary at any time by giving Us notice in writing. The consent of the beneficiary is not required for this or any other change in the Policy, unless the beneficiary is irrevocable.

**Claim Forms:** Upon receipt of a Notice of Claim, We will send You claim forms for filing Proof of Loss. If We do not send these forms to You within 15 days after You notify Us, You will have complied with Proof of Loss requirements if You give to Us within 90 days a written statement of the nature and extent of the loss. The written statement must include verification by a Physician that such Insured suffered a loss as defined in this Policy.

**Entire Contract:** This Policy, with the application and any attached Rider(s), Amendments and Endorsements, are the entire contract between You and Us. In the absence of fraud, all statements made in any application are considered representations and not warranties. No such statement unless it is contained in the written application will: (1) void the Policy; or (2) reduce the Benefits; or (3) be used in defense of a claim.

Only Our officer may change this Policy in whole or part. No change will be valid unless it is: (1) made in writing; and (2) signed by such officer; and (3) attached to this Policy. No other person, including an agent, may change this Policy or waive any of its provisions.

**Grace Period:** This Policy has a 31-day grace period. This means that if a Premium (other than the first) is not paid on or before the date it is due, it may be paid during the next 31 days after it is due or coverage will end. During the grace period the Policy will stay in force.

**Legal Action:** No legal action may be brought to recover on this Policy until 60 days after You send Us written Proof of Loss. No such action may be brought after 3 years from the time We require written Proof of Loss.

**Misstatement of Age:** If the age of an Insured has been misstated on the application, the Benefits will be those that the Premium paid would have bought at the correct age. If an Insured's age was overstated, We will refund any excess Premium if We are notified of this fact. Our liability will be limited to the refund of the Premium paid for the term not covered by the Policy if:

- a. as the result of misstatement of the age of an Insured, We accept Premiums for a term beyond the date the coverage would have ceased; or
- b. according to the correct age the coverage would not have become effective for any reason.

**Notice of Claim:** Written notice of claim must be given to Us within 90 days after a covered loss, or as soon as is reasonably possible. Notice can be given to Us at Our Administrative Office as indicated on the Cover of this Policy or to any authorized agent of the Company. Notice should include the name of the Insured and this Policy Number.

**Payment of Claims:** Loss of life Benefits, if any, will be paid to the last designated beneficiary shown in Our records. If no beneficiary designation is then in effect, the Benefits will be paid to You or Your estate. All other Benefits will be paid to You. If any accrued Benefits payable to You are unpaid when You die, We may pay them to Your estate or to Your beneficiary. If Benefits are payable to Your estate or to a minor or other person not competent to give a valid release, We may pay such Benefit, up to \$1,000, to any relative by blood or marriage to You who is deemed by Us as entitled to such Benefits.

If We made a payment in good faith under this provision, We will be released from liability to the extent of the payment.

**Physical Examination and Autopsy:** We can require an Insured to have an examination as often as necessary while a claim is pending. The examination may include: 1) a functional capacity examination; or 2) psychiatric examination; or 3) any tests that are reasonably necessary for the condition at such time. We reserve the right to select the examiner. We will pay for the examination. We can require an autopsy at Our expense in the event of an Insured's death, unless prohibited by law in the state in which the Insured lived.

**Proof of Loss:** Written proof of loss must be furnished to Us at Our Administrative Office within 180 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. Proof must be sent as soon as reasonably possible and except in the absence of legal capacity, no later than 1 year from the time proof is otherwise required. We have the right to request records as may be reasonably necessary to determine if any Benefits are payable under this Policy.

**Reinstatement:** If a Premium is not paid before the Grace Period ends, this Policy will lapse. If We accept the Premium without requiring an application for reinstatement, this Policy will be reinstated.

Once this Policy has lapsed, We require a reinstatement form or a new application to reinstate a Policy. If We approve the application, the Policy will be reinstated with a new Policy Effective Date. If We do not notify You that We have disapproved the reinstatement application, the Policy will be reinstated on the 45th day after the date We receive such application.

The reinstated Policy will cover only loss that results from: (1) an Injury that occurs after the date of reinstatement; or (2) a Sickness that starts more than 10 days after the date of reinstatement. In all other respects, Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated Policy.

After the reinstated Policy has been in force for 2 years from the date of reinstatement, We cannot cancel or deny Benefits because of any misstatement, except Fraudulent Misstatements, made by You in the reinstatement application.

Any Premiums We accept for a reinstatement will be applied to a period for which Premiums have not been paid. No Premiums will be applied to any period more than 60 days before the reinstatement date.

**Right to Review Records:** We have the right to review any records that may apply to Your claim.

**Time Limit on Certain Defenses:** After this Policy has been in force for 2 years from the Policy Effective Date, We cannot cancel or deny Benefits because of any misstatement made by You in the application for the Policy.

If a Rider is added after the Policy Effective Date, We cannot cancel or deny Benefits because of a misstatement made by You in the application after the Rider has been in force for 2 years from the Rider's Effective Date.

After the coverage has been in force beyond the Pre-Existing Conditions period, We will pay Benefits for any Pre-Existing Conditions not specifically excluded by name or description in the Policy, Rider or Endorsement.

**Time of Payment of Claims:** We will pay the Benefits then due upon receipt of written Proof of Loss and Our approval of Your claim.

**Unpaid Premium:** When a claim is paid, any Premiums due and unpaid may be deducted from the claim payment.

**Conformity with State Statutes:** Any provision of this Policy that on the Policy Effective Date is in conflict with the statutes of the state in which it was issued is amended to conform to the minimum requirements of such statutes.

**DISABILITY INCOME POLICY**

**GUARANTEED RENEWABLE TO AGE 70.  
SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS.**

**IMPORTANT NOTICE**

**PLEASE READ THE COPY OF THE APPLICATION ATTACHED TO THIS POLICY. IF ANY INFORMATION ON THE APPLICATION IS NOT TRUE AND COMPLETE, WRITE TO US AT OUR ADMINISTRATIVE OFFICE WITHIN 10 DAYS. THE APPLICATION IS A PART OF THIS POLICY, WHICH WAS ISSUED ON THE BASIS THAT THE ANSWERS TO ALL QUESTIONS AND THE INFORMATION SHOWN ON THE APPLICATION ARE CORRECT AND COMPLETE.**



**CENTRAL UNITED LIFE INSURANCE COMPANY**

[10700 Northwest Freeway, Houston, Texas 77092]

**Application for Insurance**

**FRAUD:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☐ Check if replacing or changing existing coverage in this company.

**Policy Number**

PERSONS PROPOSED FOR INSURANCE								
Last Name	First	Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security Number
			Primary Insured	/ /				
			Spouse	/ /				
			Child	/ /				
			Child	/ /				
			Child	/ /				
Address			City	State	Zip	Home Telephone ( )		
Employer			Date Employed	Hours Worked/Wk				
Occupation			Monthly Income \$			Group Number		
Payor or Owner if other than Primary Insured			<input type="checkbox"/> Payor <input type="checkbox"/> Owner	Social Security No. - -		Relationship to Primary Insured		
Beneficiary						Age	Relationship	

**FOR THE PAST 30 DAYS:** Have all proposed Insureds been performing normal activities and been actively at work full time at their regular occupation? Yes No. If "No", explain:

**USED TOBACCO** in the past 12 months? Primary Insured Yes No Spouse Yes No

**WILL THIS POLICY REPLACE OR CHANGE ANY:** Existing Life or Health Insurance in this or any other company? Yes No.  
If "Yes", complete replacement form where required.

INSURANCE PLANS								Monthly Premium	
<b>DISABILITY</b>		Monthly Ben.	Elim. Period	Benefit Period	Building Benef. Rider	50% Ben. Red. Unless % selected here			
<b>Primary Insured Only</b>									
Occ. Class	Injury	\$	\$	\$	<input type="checkbox"/>				
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	Sickness	\$	\$	\$					
<b>RIDERS</b>		AD &D	Emerg. Acc.	Hosp. Inj.	Hosp. Indem.	Outpatient Sick.	Spec. Inj.	1 <sup>st</sup> Hosp. Conf.	
Primary Insured		\$	\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	\$
Spouse		\$	\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	\$
Children		\$	\$	\$	\$	\$	<input type="checkbox"/>	<input type="checkbox"/>	\$

If Guaranteed Issue requirements are met, medical underwriting will be waived.

- HAS ANY PROPOSED INSURED:** In the last 10 years been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) and/or tested positive for HIV (Human Immunodeficiency Virus)? Yes No
- HAS ANY PROPOSED INSURED:** In the past 2 years had a driver's license suspended/revoked? Yes (License # State ) No.
- HAS ANY PROPOSED INSURED:** Consulted a Physician, received any medical treatment or been hospitalized or confined during the past 3 years? Yes No
- IS ANY PROPOSED INSURED** currently covered or eligible for Medicare? Yes No. If Yes, a "Guide to Health Insurance for People with Medicare" must be given to any proposed Insured age 65 or over.
- List the amount of any other individual disability insurance currently applied for or in force for the Primary Insured: \$

Details of "Yes" answers. Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury/Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

Home Office Corrections and/or Additions Only

**Authorization to Obtain and Release Information:** I hereby AUTHORIZE any licensed physician, medical practitioner, pharmacy or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB) consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Central United Life Insurance Company, its reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Central United Life Insurance Company may engage, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Central United Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I AGREE that all answers given in this application are complete and true to the best of my knowledge and belief, and that this application is to be attached to and made a part of the policy. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of this Authorization. This Authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing. I ACKNOWLEDGE receipt of the Notice of Information Practices and the Medical Information Bureau Disclosure Notice.

I agree and understand that no insurance coverage will be in force until the effective date specified by the Company. No Agent or Broker is authorized to make or modify any policy or waive any of Central United's rights or requirements or waive the answer to any question in the application. No change to the policy will be valid until approved by an Officer of the Company which must be noted on or attached to the policy. The policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance. I hereby apply for insurance coverage to be issued solely and entirely in reliance upon the written answers to the foregoing questions and/or information obtained by the Company in its underwriting process. I and my agent certify that I have read or had read to me all the questions and answers in this completed application and such answers to the best of my (our) knowledge and belief are true and complete. I understand and agree that the falsity of any answer or statement in this application which materially affects the acceptance of the risk or hazard assumed by the Company may bar the right to any recovery under any policy(s) issued contracts, waive any Company rights or requirements or waive any information the Company requests.

**AGENT'S STATEMENT:** I, the undersigned agent, also certify that to the best of my knowledge, replacement ☐ is ☐ is not involved at this time.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_  
City, State

X \_\_\_\_\_ X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Primary Insured Payor/Owner (if other than Proposed Insured) Spouse  
(Parent if person to be insured is less than 15 years old)

X \_\_\_\_\_ % \_\_\_\_\_  
Signature of Agent Agent's Name (printed) Agent No. % Credit State ID No.

**NOTICE: ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO CENTRAL UNITED LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

## PREMIUM DEDUCTION AUTHORIZATION TO THE EMPLOYER

You are hereby authorized to deduct \$ \_\_\_\_\_ from my pay according to the deduction mode indicated below, until further notice from me, and remit to Central United Life Insurance Company [10700 Northwest Freeway, Houston, Texas 77092].

Premiums will be deducted ☐ Weekly ☐ Monthly ☐ Bi-Monthly ☐ Other Specify \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

Employee's Signature \_\_\_\_\_ Agent's Signature \_\_\_\_\_

## BANK DRAFT AUTHORIZATION TO HONOR CHECKS DRAWN BY CENTRAL UNITED LIFE INSURANCE COMPANY

To \_\_\_\_\_

Your Bank's Address \_\_\_\_\_

As a convenience to me, I hereby request and authorize you to pay and charge my account checks drawn on my account by and payable to the order of Central United Life Insurance Company of [Houston, Texas] provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually received such notice I agree that you shall be fully protected in honoring such check. I further agree that if any such checks be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date \_\_\_\_\_ X \_\_\_\_\_  
Your signature Exactly as it appears on Bank Records Account No.

### Notice of Information Practices Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

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Central United Life Insurance Company  
[10700 Northwest Freeway, Houston, TX 77092]

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Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We will not disclose information about you without your prior written authorization except as permitted by law. In certain situations we may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business.

This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicate to us that you do not want the information disclosed for this purpose. You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Home Office at the address on the front of this Notice..

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This Supplemental Health Questionnaire is part of the application for \_\_\_\_\_ and must be attached to the base application. Primary Insured

All agreements and notices on the base application also apply to this Supplemental Health Questionnaire.

1. WITHIN THE PAST 5 YEARS, HAS ANY PROPOSED INSURED:

A). Had, been diagnosed or treated for cancer or any other malignancy?

☐ Yes ☐ No

2. WITHIN THE PAST 3 YEARS, HAS ANY PROPOSED INSURED HAD, BEEN DIAGNOSED OR TREATED FOR:

A). Any stroke or abnormal blood pressure

☐ Yes ☐ No

B). Any disorder of the stomach or intestines

☐ Yes ☐ No

C). Any disorder of the gall bladder or spleen

☐ Yes ☐ No

D). Diabetes or albumin, sugar or blood in urine

☐ Yes ☐ No

E). Any disorder of the kidneys, bladder or prostate

☐ Yes ☐ No

F). Any sexually transmitted disease, except for AIDS or HIV

☐ Yes ☐ No

G). Any disease of the breasts, tubes, ovaries or uterus

☐ Yes ☐ No

H). Tuberculosis, asthma, emphysema or any other disease of the chest or lungs

☐ Yes ☐ No

I). Dizziness, fainting spells or epilepsy, depression, mental or nervous ailment or brain disorder

☐ Yes ☐ No

J). Rheumatism, arthritis, or any bone disease

☐ Yes ☐ No

K). Any disorder of the eyes, ears, nose, mouth or throat

☐ Yes ☐ No

L). Amputation, bodily deformity, hernia, rupture or any abnormal physical or mental development

☐ Yes ☐ No

M). Hemorrhoids or varicose veins

☐ Yes ☐ No

3. WITHIN THE PAST 3 YEARS, HAS ANY PROPOSED INSURED:

A). Been advised to have any surgical operation, electrocardiogram or x-ray; or other diagnostic test

☐ Yes ☐ No

B). Been in or advised to enter a hospital or other institution for consultation, examination or treatment

☐ Yes ☐ No

4. WITHIN THE PAST 2 YEARS HAS ANY PROPOSED INSURED:

A). Flown in any aircraft other than as a fare-paying passenger in a fully licensed passenger carrying aircraft

☐ Yes ☐ No

B). Engaged in any type of racing, mountaineering, sky diving, hang gliding, bungee jumping or scuba diving activities (If Yes, complete Aviation/Hazardous Activities Form)

☐ Yes ☐ No

Details of "Yes" Answers in 2, 3 or 4. Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury or Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

5. PRESENT INSURANCE

Type	Company	Year of Issue	Amount	Benefit Period
Life Insurance				
Disability Income				

I have read or had read to me all of the questions on this Supplemental Health Questionnaire and the answers given are correct and true. I understand that all agreements and notices on the base application to which this Questionnaire is attached also apply to this Supplemental Health Questionnaire.

X \_\_\_\_\_ / 20  
Signature of Primary Insured Date

X \_\_\_\_\_ / 20  
Signature of Agent Date

AUTHORIZATION ON REVERSE SIDE MUST BE COMPLETED

**Authorization to Obtain and Release Information:** I hereby AUTHORIZE any licensed physician, medical practitioner, pharmacy or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB) consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Central United Life Insurance Company, its reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Central United Life Insurance Company may engage, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Central United Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I AGREE that all answers given in this application are complete and true to the best of my knowledge and belief, and that this application is to be attached to and made a part of the policy. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of this Authorization. This Authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing. I ACKNOWLEDGE receipt of the Notice of Information Practices and the Medical Information Bureau Disclosure Notice.

I agree and understand that no insurance coverage will be in force until the effective date specified by the Company. No Agent or Broker is authorized to make or modify any policy or waive any of Central United's rights or requirements or waive the answer to any question in the application. No change to the policy will be valid until approved by an Officer of the Company which must be noted on or attached to the policy. The policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance. I hereby apply for insurance coverage to be issued solely and entirely in reliance upon the written answers to the foregoing questions and/or information obtained by the Company in its underwriting process. I and my agent certify that I have read or had read to me all the questions and answers in this completed application and such answers to the best of my (our) knowledge and belief are true and complete. I understand and agree that the falsity of any answer or statement in this application which materially affects the acceptance of the risk or hazard assumed by the Company may bar the right to any recovery under any policy(s) issued contracts, waive any Company rights or requirements or waive any information the Company requests.

X \_\_\_\_\_ / \_\_\_\_\_ / 20  
Signature of Primary Insured or Personal Representative Date

\_\_\_\_\_  
Print Name of Primary Insured or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

*(A copy of this form will be included in any insurance policy issued based on this application.)*

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Including Fair Credit Reporting Act Notice and MIB, Inc. Notice**

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[10700 Northwest Freeway, Houston, TX 77092]**

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Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We will not disclose information about you without your prior written authorization except as permitted by law. In certain situations we may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business.

This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicate to us that you do not want the information disclosed for this purpose. You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Home Office at the address on the front of this Notice..

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PLEASE GIVE FULL DETAILS ON ALL QUESTIONS-TYPES OF PLANES, ACTIVITIES, NAMES OF ORGANIZATIONS, ETC.

1. Have you ever been issued a pilot’s license? . . . . .

YES

NO

☐

Student

☐

Private

☐

Commercial

☐

Transport

☐

b. Date issued? \_\_\_\_\_

c. Was it issued subject to physical waiver? . . . . .

☐

If so, why? \_\_\_\_\_

d. Date of last physical? \_\_\_\_\_

Was physical:

Class I

☐

Class II

☐

Class III

☐

2. If your flying activity has ended:

a. When? \_\_\_\_\_

b. Why? \_\_\_\_\_

c. Do you expect or contemplate renewal of flying activity? . . . . .

☐

☐

3. Have you ever been grounded or had your license revoked? . . . . .

☐

☐

a. When? \_\_\_\_\_

b. Why? \_\_\_\_\_

4. Have you ever served as a crew member other than pilot or co-pilot? . . . . .

☐

☐

If so, please describe \_\_\_\_\_

5. Are you, or have you ever been, a military pilot or crew member? . . . . .

☐

☐

a. When? \_\_\_\_\_

b. In what capacity? \_\_\_\_\_

c. Do you now have any military aviation activity or obligation? . . . . .

☐

☐

Describe \_\_\_\_\_

d. Date of last flight in military aircraft? \_\_\_\_\_

6. Are you a member of any aviation organization . . . .

☐

☐

If so, what? \_\_\_\_\_

7. Are you part or full owner of any type of aircraft?..

a. What type? \_\_\_\_\_

b. Is maintenance regular and complete? . . . . .

☐

☐

8. How many total hours have you accumulated:

a. as pilot or co-pilot? \_\_\_\_\_

b. As crew member other than pilot? \_\_\_\_\_

9. If you have flown as pilot, co-pilot, crew member, smoke jumper, aerial photographer, etc., within the past 24 months, or if you contemplate any such type of aviation activity in the future, please provide details of the nature and amount of activity:

NATURE OF AVIATION ACTIVITY	Hours Flown		Hours Est. Next 12 Mos.
	Past 24 mos.	Past 12 mos.	
Private flying, pleasure and/or business			
Scheduled airline			
Nonscheduled airline			
Company-owned plane			
Instructing			
Student			
Photography			
Crop treatment			
Charter, sight seeing, air taxi			
Forestry, traffic control, fish and game			
Inspection-pipe,power or telephone lines			
Experimental or testing			
Fire control			
Racing			
Stunting			
Other (describe fully)			
TYPE OF PLANE			
Propeller			
Jet or turbojet			
Glider or sailplane			
Helicopter			
Other (describe fully)			

10. Are hours listed above:

From accurate record? . . . . .

Estimated? . . . . .

11. If necessary to modify policy because of aviation, which of the following do you prefer?

a. Aviation coverage with payment of appropriate extra premium? . . . . .

b. Or, coverage limiting amount payable if death results from participating in aviation? . . . . .

Witnessed

Signed by Applicant

Dated

CUL-AAQ

PLEASE GIVE FULL DETAILS ON ALL QUESTIONS-TYPES OF PLANES, ACTIVITIES, NAMES OF ORGANIZATIONS, ETC.

	YES	NO
Do you, have you ever, or do you expect to, engage in:		
1. Any hazardous sport, avocation or hobby? . . . . . If not listed below, describe fully, showing frequency, length of time engaged in this activity, hazards, associations or clubs to which you belong, etc.	<input type="checkbox"/>	<input type="checkbox"/>
2. Rodeo competition? . . . . . Type of activity? _____ How often? _____ Date of last? _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Skin or scuba diving? . . . . . How long have you been diving? _____ How often? _____ Date of last? _____ Average depth? _____ Greatest depth? _____ Maximum time under water _____ a. Do you use S.C.U.B.A. equipment? . . . . . b. Have you ever done underwater recovery or salvage work? (When? What type?) . . . . . Would you do such work if you had the opportunity?	<input type="checkbox"/>	<input type="checkbox"/>
4. Sky diving or parachute jumping? . . . . . How long have you been sky diving? _____ How often? _____ Total number of jumps made? _____ a. Do you belong to any sky divers' association or club? (Name?) _____ b. Are all jumps made under auspices of your association or club? (If not, give details) _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Racing, performance testing or stunt driving - automobile, motorcycle, motorboat, etc.? . . . . . How long have you been participating? _____ Date of last event? _____ Location of last event? _____ a. Have you ever attended any type of drivers' or operators' school? (Name) _____ b. Do you hold a competition driver's license from any organization? (Name) _____ c. Have you ever, or do you expect to, engage in (1) other than sanctioned events? . . . . . (2) stunt driving? . . . . . (3) racing, professionally or for cashes? . . . . . d. Types and number of events and mileage in past 12 months, past 1 to 2 years, and estimated total for next 12 months? (Include midget, sports car, stock car, modified, championship, drag, go-cart, motorcycle, motorboat, hydroplane, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

Types of Events	Past 12 months		Past 1-2 Years		Est. Next 12 Month	
	Number	Miles	Number	Miles	Number	Miles

Reinstatement Application  
Attach Supplemental Health Questionnaire

**FRAUD:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

INSURED Name (Print)	Height	Weight	Date of Birth	SS #
OWNER Name (Print)	OWNER Date of Birth		Policy Number	
Street Address	City	State	Zip	Daytime Telephone ( )
State the Present Occupation and full duties of the Insured:				

- FOR THE PAST 30 DAYS:** Have all Insureds on the Policy been performing normal activities, and been actively at work full time at their regular occupation? \_\_\_\_ Yes \_\_\_\_ No. If "No", explain: \_\_\_\_\_
- WILL THIS POLICY REPLACE OR CHANGE ANY:** Existing Life or Health Insurance in this or any other Company? \_\_\_\_ Yes \_\_\_\_ No. If "Yes", complete replacement form where required.
- HAS ANY INSURED ON THE POLICY:**
  - In the last 10 years been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) and/or tested positive for HIV (Human Immunodeficiency Virus)? \_\_\_\_ Yes \_\_\_\_ No
  - Consulted a Physician, received any medical treatment, or been hospitalized during the past 3 years? \_\_\_\_ Yes \_\_\_\_ No
  - In the past 2 years had a driver's license suspended/revoked? \_\_\_\_ Yes (License # \_\_\_\_\_ State \_\_\_\_\_) \_\_\_\_ No

Details of "Yes" Answers in 3 Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury or Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

**Insurance Information Practices:** This notice describes the practices We, Central United Life Insurance Company and Your agent follow to manage Your personal information. We will rely on the information You, the Primary Insured, provide in this application to decide if You and Your dependents are insurable. We or Your agent may telephone You to confirm information given in this application or to obtain additional information needed to process Your application. Before asking other sources for information about You or Your dependents, We will get Your written authorization. Information You provide or authorize may be disclosed to third parties without authorization. You have the right to access and correct the information collected about You and Your dependents except information that relates to a claim or civil or criminal proceeding. You will be given upon request Our detailed Description of Information Practices by writing to Us at [10700 Northwest Freeway, Houston, TX 77092].

**Agreement:** The statements and answers in this Reinstatement Application are true and correct to the best of Our knowledge and belief. I understand that: (a) the Time Limit on Certain Defenses or Incontestability clause in the Policy will start anew from the date the Policy is reinstated as to any answer made in this application; and (b) any material misrepresentation may result in loss of coverage under the Policy. I also further agree that the Policy shall not be considered reinstated until this application is approved by the Company at its Administrative Office during the lifetime and continued insurability of all Insureds under the Policy. Any payment of premiums made in advance, or any receipt therefore, shall not be binding upon the Company until this application is approved. If the Policy is not reinstated, I agree to accept the return of all advance payments made in connection with this Reinstatement Application without interest.

X \_\_\_\_\_ Signed at \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / 20  
Signature of Primary Insured City, State Date  
(Parent if person to be insured is less than 15 years old)

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Owner (If other than Primary Insured) Spouse

X \_\_\_\_\_ / \_\_\_\_ / 20  
Signature of Agent Date Agent's No. State ID No.



**Authorization to Obtain and Release Information:** I hereby AUTHORIZE any licensed physician, medical practitioner, pharmacy or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB) consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Central United Life Insurance Company, its reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Central United Life Insurance Company may engage, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Central United Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I AGREE that all answers given in this application are complete and true to the best of my knowledge and belief, and that this application is to be attached to and made a part of the policy. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of this Authorization. This Authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing. I ACKNOWLEDGE receipt of the Notice of Information Practices and the Medical Information Bureau Disclosure Notice.

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X \_\_\_\_\_ / \_\_\_\_\_ / 20  
Signature of Primary Insured or Personal Representative Date  
\_\_\_\_\_  
Print Name of Primary Insured or Personal Representative  
\_\_\_\_\_  
Description of Personal Representative's Authority

*(A copy of this form will be included in any insurance policy issued based on this application.)*

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[10700 Northwest Freeway, Houston, TX 77092]**

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Policy No.(s) \_\_\_\_\_

☐ **Section 1: Change of Beneficiary**

Name and Address of Primary Beneficiary	Relationship *	Date of Birth	Social Security #	Settlement Request, If Any (Use percentage only. Do not use dollar amounts)
Name and Address of Contingent Beneficiary	Relationship *	Date of Birth	Social Security #	Settlement Request, If Any (Use percentage only. Do not use dollar amounts)

The insured reserves the right to further change the beneficiary without the consent of the beneficiary.

☐ **Section 2: Change of Name**

From: \_\_\_\_\_ To: \_\_\_\_\_  
                    Last                    First                    Middle                    Last                    First                    Middle

By Reason of: ☐ Correction ☐ Marriage ☐ Court Order \*\* ☐ Other \_\_\_\_\_

Prior Signature: \_\_\_\_\_ (\*\*Copy of legal document required)

☐ **Section 3: Request for Certificate of Lost Policy or Duplicate Policy**

<input type="checkbox"/> Request for Certificate of Lost Policy (Policy over 5 years in age)	Reason for Request <input type="checkbox"/> Cannot Locate Original Policy
<input type="checkbox"/> Request for Duplicate Policy (\$15 fee applies) (Policy under 5 years in age)	<input type="checkbox"/> Never Received Original Policy
	<input type="checkbox"/> Other _____

☐ **Section 4: Accident and Health Cancellation of Coverage Only**

I, \_\_\_\_\_, owner of the above policy(ies), would like to cancel.

☐ **Section 5: Ownership Change**

Change Owner From: \_\_\_\_\_  
  Last  First  Middle

To: \_\_\_\_\_ Social Security # \_\_\_\_\_  
  Last  First  Middle

Address: \_\_\_\_\_  
  Street Address  City  State  Zip Code

Title (Only complete if a corporation, partnership or trust): \_\_\_\_\_

Signature of New Owner: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Old Owner: \_\_\_\_\_ Date: \_\_\_\_\_

\* Please refer to Section 8 regarding Trusts and Trustees

Continued on reverse side

☐ **Section 6: Change In Benefit Or Coverage**

Policy # \_\_\_\_\_ (If coverage is to increased, a new application is required)

Benefit Amount from \$ \_\_\_\_\_ to \$ \_\_\_\_\_

Decrease Coverage for: ☐ Spouse ☐ Child ☐ Other \_\_\_\_\_

Specific Details/Instructions: \_\_\_\_\_

☐ **Section 7: Other**

☐ **Section 8: Trusts and Trustees**

Name of Trust: \_\_\_\_\_

Name of Trustee(s): \_\_\_\_\_

Date of Trust: \_\_\_\_\_

We hereby certify that the Trustee(s) named are the Trustee(s) for the named Trust, which is in full force and effect. The Company shall not be obligated to inquire into the terms of any trust agreement affecting this policy/certificate and shall not be chargeable with knowledge of the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named to any receipt, release or waiver, or to any transfer or other instrument affecting this policy/certificate or any options, privileges or benefits thereunder. Unless otherwise indicated on a Certification of Trust form the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy/certificate. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy/certificate. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

☐ **Section 9: Community Property Release**

This section is applicable for Community Property states (AZ, CA, LA, NV, NM, TX, WA and WI).

Determination of Community Property status depends on the current or former resident state of the policy/certificate owner.

Spouse's/Formal Spouse's Signature \_\_\_\_\_

Date \_\_\_\_\_

Name (print or type) \_\_\_\_\_

☐ The owner certifies that this policy is not subject to Community Property laws

Owner's Signature \_\_\_\_\_

Date \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Witness: \_\_\_\_\_

Signature of Insured: \_\_\_\_\_

Required

Signature of Other: \_\_\_\_\_

Required if other than primary Insured

Owner's Mailing Address: \_\_\_\_\_

Street Address

City

State

Zip Code

**CENTRAL UNITED LIFE INSURANCE COMPANY**  
**[10700 Northwest Freeway, Houston, Texas 77092]**

**DISABILITY INCOME POLICY**  
**POLICY FORM CDI10-AR**

**REQUIRED OUTLINE OF COVERAGE**

**THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.**

**PARAGRAPH 1. Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Your insurance company. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**

**PARAGRAPH 2.** Disability income coverage is designed to provide You with coverage for disabilities resulting from a covered Injury or a covered Sickness. Coverage is provided for the Benefits outlined in paragraph (3). The Benefits described in paragraph (3) may be limited by paragraph (4).

**PARAGRAPH 3** **BENEFITS**

**Injury Disability Benefit**

We will pay the Monthly Benefit for Disability (subject to the Benefit Reduction section) due to an Injury if:

- a. Total Disability due to an Injury continues beyond the Elimination Period (the Elimination Period does not apply to a Presumptive Disability); and
- b. the Injury: 1) occurred after the Policy Effective Date; and 2) occurred while the Policy was in force; and 3) was not subject to the Pre-Existing Conditions provision; and 4) has not been specifically excluded by name or description in the Policy; and
- c. You lose income due to such Total Disability.

If Disability begins more than 60 days after an Injury, Disability will be considered to be the result of a Sickness. The Injury must occur while the Policy is in force.

Benefits will be payable until the earliest of the following:

- a. the date You cease to be Totally Disabled (does not apply to a Presumptive Disability); or
- b. the date You fail to provide satisfactory proof of continued Total Disability when requested; or
- c. the date You are outside of the United States, its possessions, or Canada (does not apply to a Presumptive Disability); or
- d. the date the Maximum Benefit Period ends; or
- e. the date You die.

We will only pay up to the applicable Maximum Benefit Period for any one Disability. The Maximum Benefit Period At Age 65 may differ.

**Sickness Disability Benefit**

We will pay the Monthly Benefit for Disability (subject to the Benefit Reduction section) due to a Sickness if:

- a. Total Disability due to a Sickness continues beyond the Elimination Period (the Elimination Period does not apply to a Presumptive Disability); and
- b. the Sickness: 1) begins after the Policy Effective Date; and 2) begins while the Policy is in force; and 3) was not subject to the Pre-Existing Conditions provision; and 4) has not been specifically excluded by name or description in the Policy; and
- c. You lose income due to such Total Disability.

If Disability begins more than 60 days after an Injury, Disability will be considered to be the result of a Sickness. The Injury must occur while the Policy is in force.

Benefits will be payable until the earliest of the following:

- a. the date You cease to be Totally Disabled (does not apply to a Presumptive Disability); or
- b. the date You fail to provide satisfactory proof of continued Total Disability when requested; or
- c. the date You are outside of the United States, its possessions, or Canada (does not apply to a Presumptive Disability); or
- d. the date the Maximum Benefit Period ends; or
- e. the date You die.

We will only pay up to the applicable Maximum Benefit Period for any one Disability. The Maximum Benefit Period At Age 65 may differ.

### **Benefit Reduction**

Your Benefit may differ if You receive or are eligible to receive any Other Income. Other Income must be for the same period You are entitled to a Monthly Benefit for Disability due to an Injury or Sickness. The percentage that the Monthly Benefit will reduce in such case is shown on the Policy Schedule.

We have the right to require reasonable proof of Other Income You receive or are eligible to receive during any month of Disability. We have the right to recover from You any amount of Benefits overpaid as a result of a retroactive award of Other Income Benefits.

### **Partial Disability Benefit**

We will pay a Partial Disability Benefit if:

- a. You have received Total Disability Benefits under the Policy for at least 2 consecutive months; and
- b. You are Partially Disabled the day following the date Total Disability ended; and
- c. Partial Disability is the result of the same Injury or Sickness which caused the Total Disability; and
- d. Your earnings are not greater than 80% of Your Monthly Base Earnings.

The Partial Disability Benefit will be the lesser of: 1) 50% of the Monthly Benefit for Disability that You were eligible to receive during the prior month before Partial Disability began; or 2) the difference between Your current earnings and Your Monthly Base Earnings. The Partial Disability Benefit will be payable for a maximum period of 3 months. The combined period of time Benefits are payable for Total Disability and Partial Disability will not exceed the Maximum Benefit Period. The Maximum Benefit Period At Age 65 may differ.

The Partial Disability Benefit will be paid until the earliest of:

- a. the date You cease to be Partially Disabled; or
- b. the date You fail to provide satisfactory proof of continued Partial Disability when requested; or
- c. the date You are outside of the United States, its possessions, or Canada (Limitations & Exclusions); or
- d. the date the Maximum Benefit Period ends; or
- e. 3 months; or
- f. the date Your earnings are greater than 80% of Your Monthly Base Earnings; or
- g. the date you die.

We can require that You send Us appropriate financial records to prove Your income during the time You are Partially Disabled.

### **Maximum Benefit Period At Age 65**

The Maximum Benefit Period for any new Disability that begins after age 65 will be the lesser of Your current Maximum Benefit Period or 12 months.

### **Total, Presumptive or Partial Disability Benefit for Part of a Month**

If a Benefit is payable for less than a full month, We will pay one-thirtieth of the applicable Benefit for each day of Total, Presumptive or Partial Disability.

### **When a Recurrent Disability Becomes a New Disability**

A Recurrent Disability will be treated as the same Disability unless the requirements of the paragraph below are met. This means the Elimination Period and Maximum Benefit Period for Disability in the

Policy will not start over. Any Recurrent Disability caused by a Pre-Existing Condition will be treated as the same Disability.

The only time a Recurrent Disability is treated as a new Total Disability is if You have returned to work for six months or more. During this time, You must have been working the lesser of: 1) the same number of hours You were working before the first Total Disability for the same or related condition; or 2) Full-Time. The Elimination Period and Maximum Benefit Period will start over for a new Total Disability.

A Recurrent Disability caused by a Presumptive Disability will never be classified as a new Disability. It will always be considered as the same Disability even if the requirements of the above paragraph are met.

### **Concurrent Disability**

We will pay Benefits for only one Disability at a time even if it results from more than one cause. If Disability results from more than one cause, it will be considered the same Disability. You will be entitled to only one Benefit.

### **Survivor Benefit**

If You die while receiving Disability Benefits for at least 6 consecutive months, We will pay a Survivor Benefit. The Survivor Benefit will be a lump sum of 6 times the Disability Benefit You are eligible for the calendar month before death. The Survivor Benefit will be paid to Your designated beneficiary or to Your estate if a beneficiary is not named.

### **Waiver of Premiums**

After You have received Benefits for Total or Presumptive Disability for 90 consecutive days. Starting the 91<sup>st</sup> day or the next due date, We will waive future Premiums. We will waive the Premium as long as You are receiving Benefits for Total, Presumptive or Partial Disability. However, We will not waive Premiums beyond the Maximum Benefit Period.

## **PARAGRAPH 4**

## **LIMITATIONS AND EXCLUSIONS**

### **PART I**

The Policy (including any Rider(s) attached) does not cover losses sustained while caused by, contributed to or resulting from:

- a. being legally intoxicated as defined by State law where the loss occurred or being under the influence of any narcotic unless administered on the advice of a Physician; or
- b. alcoholism or drug addiction or Sickness or Injury from the use of alcohol and/or the use of drugs not prescribed by a Physician; or
- c. attempted suicide while sane or insane or intentionally self-inflicted Injury; or
- d. Mental or Nervous Disorders; or
- e. being exposed to war or any act of war, declared or undeclared or while serving in the armed forces; or
- f. engaging in an illegal activity; or
- g. participation in any form of aviation other than as a fare-paying passenger in a fully licensed passenger carrying aircraft; or
- h. voluntary inhalation of gas; or
- i. mountaineering, sky diving, hang gliding or bungee jumping; or
- j. riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
- k. conditions specifically excluded by Amendment or Endorsement; or
- l. any Pre-Existing Conditions as defined in the Policy.

### **PART II**

The Policy (including any Rider(s) attached) does not pay Benefits for:

- a. care that is primarily for: 1) rest; or 2) convalescence; or 3) rehabilitation; or
- b. treatment which is rendered outside the United States, its possessions, or Canada, except for emergency care for acute onset of Sickness or Injury sustained while traveling for business or

- pleasure; or
- c. Total or Partial Disability while You are outside of the United States, its possessions, or Canada; or
- d. Dental Treatment or plastic surgery for cosmetic purposes. This exclusion does not apply if the treatment or surgery is: 1) due to an Injury; or 2) to restore normal bodily functions; or
- e. Total or Presumptive Disability that begins while not Employed.

We will not pay Benefits for any period the Insured is incarcerated in any type of penal institution.

## PARAGRAPH 5

## OPTIONAL BENEFIT RIDERS

(Available with additional premium)

**Emergency Accident Rider:** If an Insured is Injured and requires Emergency Care by a Physician, We will pay a Benefit Amount shown in the Policy Schedule. The treatment must be rendered in an emergency room of a Hospital or in a Physician's office and received within 72 hours of the Injury. Benefits are limited to 4 treatments per Insured in a Calendar Year with the exception of Eligible Dependent Children. The Benefits for Eligible Dependent Children are limited to a combined total of 4 different Emergency Care treatments each Calendar Year.

**Outpatient Sickness Rider:** If an Insured requires outpatient treatment due to a Sickness and such treatment is rendered in: a) an out-of-Hospital facility, We will pay the Benefit Amount; or b) a Hospital emergency room, We will pay 1.5 times the Benefit Amount. The Benefit Amount is shown in the Policy Schedule. Benefits are limited to 4 different Sicknesses each Calendar Year with the exception of Eligible Dependent Children. The Benefits for Eligible Dependent Children are limited to a combined total of 4 different Sicknesses each Calendar Year.

**Accidental Death Benefit & Dismemberment Rider:** We will pay the applicable Benefit Amount shown in the Policy Schedule if such person(s) sustains an Injury, which results in death within 90 days of the Injury. If such death results from an Injury sustained while a fare-paying passenger in a common carrier, the amount payable will be twice the applicable Benefit Amount. We will pay the applicable Benefit Amount for an Injury which, within 90 days results in: a) loss of the sight of both eyes entirely, irrecoverably and uncorrectable; or b) severance of both hands at or above the wrist joint or both feet at or above the ankle joint; or c) severance of one hand at or above the wrist joint and one foot at or above the ankle joint. We will pay one-half the applicable Benefit Amount for an Injury which, within 90 days results in: a) loss of the sight of one eye entirely, irrecoverably and uncorrectable; or b) severance of one hand at or above the wrist joint or one foot at or above the ankle joint. The total amount We will pay for all losses as the result of any one Injury will not exceed the applicable Benefit Amount except for death resulting from a common carrier accident as described above.

**Hospital Injury Indemnity Rider:** We will pay the Benefit Amount shown in the Policy Schedule for a Hospital Confinement which: a) begins while the Rider is in force for the Insured; b) is at the direction and supervision of a Physician; and c) for treatment of an Injury. The maximum number of days We will pay during a Period of Confinement is 365.

**Specified Injury Benefit Rider:** We will pay the following Benefits: **Appliance:** We will pay \$25 if an Insured is Injured and is required to use an appliance as a result of the Injury. Dental appliances or orthodontia will not be covered. A Physician must advise the use of an appliance and the Insured must begin using it within 90 days after the Injury. **Ambulance:** We will pay \$25 if an Insured is Injured and requires transportation by a professional ambulance service to a Hospital within 90 days after the Injury. **Blood/Plasma:** We will pay \$50 if an Insured is Injured and requires blood/plasma within 90 days after the Injury. **Burns:** We will pay \$600 if an Insured receives burns in an Injury and is treated by a Physician within 72 hours after the Injury. The burns must be second degree burns that cover at least 36% of the body surface or third degree burns that cover at least nine square inches of the body surface. **Dislocation (Separated Joint):** We will pay a scheduled benefit if an Insured receives a dislocation due to an Injury which is diagnosed by a Physician as a dislocation within 90 days after the Injury and which requires correction with the use of Anesthesia. Modified benefit amounts apply if an Insured receives more than one dislocation in an Injury, if a dislocation

does not require anesthesia, if the dislocation is an incomplete dislocation or if an Insured receives a fracture and a dislocation in the same Injury. **Eye Injury:** We will pay \$100 if an Insured receives an eye injury requiring surgery with anesthesia that is performed by a Physician within 90 days after the Injury. **Fracture (Broken Bone):** We will pay a scheduled benefit if an Insured receives a fracture in an Injury which is diagnosed by a Physician within 90 days after the Injury and which requires correction by a Physician. Modified benefit amounts apply if an Insured receives more than one fractured bone in an Injury, a chop fracture, or if the Insured receives a fracture and a dislocation in the same Injury. **Ruptured Disk:** If an Insured receives a ruptured disk in an Injury which is treated by a Physician within 90 days after the Injury and repaired with surgery within one year after the Injury, We will pay \$100 if such Injury occurs less than one year after the Rider effective date and \$400 if such Injury occurs one year or more after the Rider effective date. **Tendon/Ligament:** If an Insured receives an Injury to a tendon/ligament causing it to be torn, ruptured or severed and which is repaired within 90 days of the Injury, We will pay \$500 for repair of one tendon or ligament and \$750 for repair of all tendons/ligaments if more than one. **Torn Knee Cartilage:** If an Insured receives a torn knee cartilage (meniscus) in an Injury which is treated by a Physician within 90 days of the Injury and repaired by a Physician with surgery within one year after the Injury, We will pay \$100 if the Injury occurs less than one year after the Rider effective date and \$400 if the Injury occurs one year or more after the Rider effective date. **Gunshot Wound:** We will pay \$1,000 if You are Injured by a gunshot wound caused by a projectile from a conventional firearm and You did not intentionally shoot Yourself. It must require treatment by a Physician, including Hospital Confinement within 24 hours and surgery within 72 hours after the Injury. There are no Gunshot Wound benefits for Insured Dependents. If You are shot more than once in a 24-hour period, We will pay Benefits only for the first wound. Modified benefits apply if You receive a fracture or a dislocation as the result of the same gunshot wound accident. The following limitations and exclusions apply to this Benefit in addition to those contained in the Hospital Confinement Policy: a) riding in or driving any motor-driven vehicle in a race, stunt show or speed test; b) driving a car or any other licensed vehicle on a highway without a valid operator's license; c) mountaineering, sky diving, hang gliding or bungee jumping; or d) Insured Dependent(s) practicing for or participating in any high school, college, semi-professional or professional competitive athletic contest. This does not apply to intramural sports. Sickness is not covered under the Specified Injury Rider.

**First Hospital Confinement Rider:** We will pay the Benefit Amount shown for an Insured's First Hospital Confinement which: a) is due to Injury or Sickness; b) begins while the Rider is in force for the Insured; and c) is at the direction of and under the supervision of a Physician. The Benefit Amount is not a cumulative benefit and will not exceed \$5,000 for each Insured each Calendar Year.

Total Days of Hospital Confinement	Benefit Amount
One	\$500
Two	\$1,000
Three	\$2,000
Four	\$3,000
Five	\$4,000
Six	\$5,000

**Building Benefit Rider:** Amends the Maximum Benefit Period definition in the Policy as follows: The longest period of time that the Benefit could be payable. The Maximum Benefit Period increases based upon the number of Rider Years the Rider has been in force. The Maximum Benefit Period will not change during the time You are receiving Benefits for Disability.

**Hospital Indemnity Rider:** We will the Benefit Amount shown in the Policy Schedule for each day the Insured is Confined in a Hospital up to a maximum during a Period of Confinement of 365 days.



**PARAGRAPH 6**

**RENEWABILITY**

The Policy is Guaranteed Renewable to age 70 subject to the terms and conditions of the Policy.

**PARAGRAPH 7**

**PREMIUM**

We reserve the right to change the Premium rates. If We do this, We will give You 45 days notice of such change. The Policy provides a 31-day grace period during which period the Policy will remain in force. The Initial Premium for Base Policy and Optional Riders is shown in the Policy Schedule.

Initial Premium for Base Policy: \_\_\_\_\_  
Initial Premium for Optional Rider(s): \_\_\_\_\_  
Total Initial Premium due with Application: \_\_\_\_\_

# CENTRAL UNITED LIFE INSURANCE

Home Office: [Little Rock, AR 72201]

Administrative Office: [10700 Northwest Freeway Houston, TX 77092] [800-669-9030]

## BUILDING BENEFIT RIDER

Rider Effective Date: \_\_\_\_\_  
(If other than the Policy Effective Date)

### PLEASE READ THIS RIDER CAREFULLY.

This Rider is effective as of the Policy Effective Date unless a different Rider Effective Date is shown above.

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of the application and receipt of the first Premium. All Definitions, Provisions, Limitations and Exceptions of the Policy apply to this Rider, except as modified by this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

### DEFINITIONS

**Rider Year(s):** The number of yearly anniversaries from the Rider Effective Date above.

### ENDORSEMENT

The definition of Maximum Benefit Period in the Definition provision section is deleted in its entirety and replaced with the following:

**Maximum Benefit Period:** The longest period of time that the Benefit could be payable. The Maximum Benefit Period increases based upon the number of Rider Years this Rider has been in force. The Maximum Benefit Period will not change during the time You are receiving Benefits for Disability.

The Maximum Benefit Period shown on the Policy Schedule will determine which of the tables below applies to You.

#### If Maximum Benefit Period on the Policy Schedule is 6 months.

<u>Rider Year(s)</u>	<u>Maximum Benefit Period</u>
0	6 months
1	6 ½ months
2	7 months
3-4	7 ½ months
5 & Over	9 months

#### If Maximum Benefit Period on the Policy Schedule is 12 months.

<u>Rider Year(s)</u>	<u>Maximum Benefit Period</u>
0	12 months
1	13 months
2	14 months
3-4	15 months
5 & Over	18 months

#### If Maximum Benefit Period on the Policy Schedule is 24 months.

<u>Rider Year(s)</u>	<u>Maximum Benefit Period</u>
0	24 months
1	26 months
2	28 months
3-4	30 months
5 & Over	36 months

## TERMINATION

This Rider ends on the earlier of the date:

- a. Your coverage terminates under the Policy to which this Rider is attached; or
- b. any Premium for this Rider is not paid before the end of the Grace Period; or
- c. You give Us a written request to end this Rider.

## PREMIUMS

While this Rider is in force, Premiums are due based on the terms of the Policy to which this Rider is attached.

We reserve the right to change the Premiums for this Rider. When this occurs, the new rate will be guaranteed for a period of not less than 12 months. We may change the Premiums if:

- a. We change the Premiums for all riders of this same form and issue age in Your state of issue; and
- b. such change complies with the laws and regulations of Your state of issue; and
- c. We give You 45 days written notice before such change becomes effective.

**Other than as stated above, this Rider shall not alter, waive or extend any other provisions of the Policy to which this Rider is attached.**



[Dan George  
President]

# CENTRAL UNITED LIFE INSURANCE COMPANY

Home Office: [Little Rock, AR 72201]

Administrative Office: [10700 Northwest Freeway Houston, TX 77092] [800-669-9030]

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## EMERGENCY ACCIDENT RIDER

Rider Effective Date: \_\_\_\_\_  
(If other than the Policy Effective Date)

### PLEASE READ THIS RIDER CAREFULLY.

This Rider is effective as of the Policy Effective Date unless a different Rider Effective Date is shown above.

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of the application and receipt of the first Premium. All Definitions, Provisions, Limitations and Exceptions of the Policy apply to this Rider except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

### DEFINITIONS

**Emergency Care:** Medical treatment for an Injury demanding immediate attention.

**Calendar Year:** The period starting on the Policy Effective Date and ending on December 31 of the same year. From then on, it is the period starting on January 1 and ending on December 31.

**Injury/Injured:** Bodily injuries sustained which:

- a. are directly caused by an accident, independent and unrelated of all other causes; and
- b. have not been specifically excluded by name or description in the Policy or this Rider; and
- c. are not caused or contributed to by Sickness; and
- d. occur while this Rider is in force for the Insured.

Losses that occur after the Pre-Existing Condition provision has been satisfied will be covered for an Injury that occurred before the date the person becomes an Insured under this Rider unless the Injury has been specifically excluded by name or description within the Policy or Rider.

### BENEFITS

If an Insured is Injured and requires Emergency Care by a Physician, We will pay the Benefit Amount shown on the Policy Schedule for such Insured. The treatment must be:

- a. rendered in an emergency room of a Hospital or in a Physician's office; and
- b. received within 72 hours of the Injury.

This Rider pays a Benefit for only one Emergency Care treatment per Injury. Any other Emergency Care treatments for the same Injury will not be subject to a Benefit. Benefits for Emergency Care treatments are limited to 4 such treatments per Insured in a Calendar Year, with the exception of Eligible Dependent Children. The Benefits for Eligible Dependent Children, not for each covered child, are limited to a combined total of 4 different Emergency Care treatments each Calendar Year.

### TERMINATION

This Rider ends on the earlier of the date:

- a. Your coverage terminates under the Policy to which this Rider is attached; or
- b. any Premium for this Rider is not paid before the end of the Grace Period; or
- c. You give Us a written request to end this Rider.

Coverage for an Insured Dependent will end under this Rider when such Insured ceases to be an Eligible Dependent Child or Eligible Spouse, as defined in the Policy.

## PREMIUMS

While this Rider is in force, Premiums are due based on the terms of the Policy to which this Rider is attached.

We reserve the right to change the Premiums for this Rider. When this occurs, the new rate will be guaranteed for a period of not less than 12 months. We may change the Premiums if:

- a. We change the Premiums for all riders of this same form and issue age in Your state of issue; and
- b. such change complies with the laws and regulations of Your state of issue; and
- c. We give You 45 days written notice before such change becomes effective.

**Other than as stated above, this Rider shall not alter, waive or extend any other provisions of the Policy to which this Rider is attached.**



[Dan George  
President]

**CENTRAL UNITED LIFE INSURANCE COMPANY**  
*Home Office: [Little Rock, AR 72201]*  
*Administrative Office: [10700 Northwest Freeway Houston, TX 77092] [800-669-9030]*

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**OUTPATIENT SICKNESS RIDER**

Rider Effective Date: \_\_\_\_\_  
(If other than the Policy Effective Date)

**PLEASE READ THIS RIDER CAREFULLY.**

This Rider is effective as of the Policy Effective Date unless a different Rider Effective Date is shown above.

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of the application and receipt of the first Premium. All Definitions, Provisions, Limitations and Exceptions of the Policy apply to this Rider, except as modified by this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

**DEFINITIONS**

**Calendar Year:** The period starting on the Policy Effective Date and ending on December 31 of the same year. From then on, it is the period starting on January 1 and ending on December 31.

**Sickness:** Disease or illness, including pregnancy, which: (1) is diagnosed or treated while this Rider is in force for the Insured; and (2) does not result from Pre-Existing Conditions as defined; and (3) has not been specifically excluded by name or description in the Policy or this Rider.

**BENEFITS**

If an Insured requires outpatient treatment due to a Sickness and such treatment is rendered in:

- |    |                               |   |
|----|-------------------------------|---|
| a. | an out-of-Hospital facility - | We will pay the Benefit Amount shown on the Policy Schedule for such Insured per Sickness |
| b. | a Hospital emergency room -   | We will pay 1.5 times the Benefit Amount shown on the Policy Schedule per Sickness        |

Outpatient treatment must be by a Physician.

This Rider pays a Benefit for only one outpatient treatment per Sickness. Any other outpatient treatments for the same Sickness will not be subject to a Benefit. Benefits are limited to 4 different Sicknesses per Insured each Calendar Year, with the exception of Eligible Dependent Children. The Benefits for Eligible Dependent Children, not for each covered child, are limited to a combined total of 4 different Sicknesses each Calendar Year.

**TERMINATION**

This Rider ends on the earlier of the date:

- a. Your coverage terminates under the Policy to which this Rider is attached; or
- b. any Premium for this Rider is not paid before the end of the Grace Period; or
- c. You give Us a written request to end this Rider.

Coverage for an Insured Dependent will end under this Rider when such Insured ceases to be an Eligible Dependent Child or Eligible Spouse, as defined in the Policy.

## PREMIUMS

While this Rider is in force, Premiums are due based on the terms of the Policy to which this Rider is attached.

We reserve the right to change the Premiums for this Rider. When this occurs, the new rate will be guaranteed for a period of not less than 12 months. We may change the Premiums if:

- a. We change the Premiums for all riders of this same form and issue age in Your state of issue; and
- b. such change complies with the laws and regulations of Your state of issue; and
- c. We give You 45 days written notice before such change becomes effective.

**Other than as stated above, this Rider shall not alter, waive or extend any other provisions of the Policy to which this Rider is attached.**



[Dan George  
President]

# CENTRAL UNITED LIFE INSURANCE COMPANY

Home Office: [Little Rock, AR 72201]

Administrative Office: [10700 Northwest Freeway Houston, TX 77092] [800-669-9030]

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## ACCIDENTAL DEATH AND DISMEMBERMENT RIDER

Rider Effective Date: \_\_\_\_\_  
(If other than the Policy Effective Date)

### PLEASE READ THIS RIDER CAREFULLY.

This Rider is effective as of the Policy Effective Date unless a different Rider Effective Date is shown above.

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of the application and receipt of the first Premium. All Definitions, Provisions, Limitations and Exceptions of the Policy apply to this Rider, except as modified by this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

### DEFINITIONS

**Injury/Injured:** Bodily injuries sustained which:

- a. are directly caused by an accident, independent of all other causes; and
- b. have not been specifically excluded by name or description in the Policy or this Rider; and
- c. are not caused or contributed to by Sickness; and
- d. occur while this Rider is in force for the Insured.

Losses that occur after the Pre-Existing Condition provision has been satisfied will be covered for an Injury that occurred before the date the person becomes an Insured under this Rider unless the Injury has been specifically excluded by name or description within the Policy or Rider.

### BENEFITS

- A. Accidental Death Benefit.** If an Insured is Injured, which results in death within 90 days of the Injury, We will pay the Benefit Amount shown on the Policy Schedule for such Insured. Such sum will be paid to Your designated beneficiary or to Your estate. If an Insured Dependent dies, the Benefit Amount will be paid to You.

If such death results from an Injury an Insured sustains while a fare-paying passenger in a common carrier, the amount payable will be twice the Benefit Amount shown on the Policy Schedule for such Insured. A common carrier is one licensed and operated exclusively to transport persons and charges a fare.

- B. Accidental Dismemberment and Loss of Sight Benefit:** We will pay the Benefit Amount shown on the Policy Schedule if an Insured was Injured and has an Injury that within 90 days results in the:

- a. loss of the sight of both eyes entirely, irrecoverably and uncorrectably; or
- b. severance of both hands at or above the wrist joint or both feet at or above the ankle joint; or
- c. severance of one hand at or above the wrist joint and one foot at or above the ankle joint.

We will pay one-half of the Benefit Amount shown on the Policy Schedule if an Insured is Injured and has an Injury that within 90 days results in the:

- a. loss of the sight of one eye entirely, irrecoverably and uncorrectably; or
- b. severance of one hand at or above the wrist joint or one foot at or above the ankle joint.

We will pay one-half of the Benefit Amount for such Insured who incurred the loss.

- C. Limit on Payment under this Rider:** The total amount We will pay for all losses, stated in Sections A and B above as the result of any one Injury, will not exceed the Benefit Amount shown on the Policy Schedule. The only exception is if an Insured's death results from a common carrier accident, We will pay twice the Benefit Amount shown on the Policy Schedule for such Insured.



## TERMINATION

This Rider ends on the earlier of the date:

- a. Your coverage terminates under the Policy to which this Rider is attached; or
- b. any Premium for this Rider is not paid before the end of the Grace Period; or
- c. You give Us a written request to end this Rider.

Coverage for an Insured Dependent will end under this Rider when such Insured ceases to be an Eligible Dependent Child or Eligible Spouse, as defined in the Policy.

## PREMIUMS

While this Rider is in force, Premiums are due based on the terms of the Policy to which this Rider is attached.

We reserve the right to change the Premiums for this Rider. When this occurs, the new rate will be guaranteed for a period of not less than 12 months. We may change the Premiums if:

- a. We change the Premiums for all riders of this same form and issue age in Your state of issue; and
- b. such change complies with the laws and regulations of Your state of issue; and
- c. We give You 45 days written notice before such change becomes effective.

**Other than as stated above, this Rider shall not alter, waive or extend any other provisions of the Policy to which this Rider is attached.**



[Dan George  
President]

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## HOSPITAL INJURY INDEMNITY RIDER

Rider Effective Date: \_\_\_\_\_  
(If other than the Policy Effective Date)

### PLEASE READ THIS RIDER CAREFULLY.

This Rider is effective as of the Policy Effective Date unless a different Rider Effective Date is shown above.

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of the application and receipt of the first Premium. All Definitions, Provisions, Limitations and Exceptions of the Policy apply to this Rider, except as modified by this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

### DEFINITIONS

**Injury/Injured:** Bodily injuries sustained which:

- a. are directly caused by an accident, independent and unrelated of all other causes; and
- b. have not been specifically excluded by name or description in the Policy or this Rider; and
- c. are not caused or contributed to by Sickness; and
- d. occur while this Rider is in force for the Insured.

Losses that occur after the Pre-existing Condition provision has been satisfied will be covered for an Injury that occurred before the date the person becomes an Insured under this Rider unless the Injury has been specifically excluded by name or description within the Policy or Rider.

**Period of Confinement:** One continuous Hospital Confinement or several Hospital Confinements for the same or a related cause, which are separated by less than 60 days. Each Hospital Confinement must begin while the coverage is in force for the Insured.

### BENEFITS

For the Hospital Injury Indemnity Benefit Amount to be payable, the Hospital Confinement must:

- a. begin while this Rider is in force for the Insured; and
- b. be at the direction and supervision of a Physician; and
- c. be for treatment of an Injury.

The Benefit Amount is the amount shown on the Policy Schedule of the Policy to which this Rider is attached. The maximum number of days that We will pay during a Period of Confinement is 365.

### TERMINATION

This Rider ends on the earlier of the date:

- a. Your coverage terminates under the Policy to which this Rider is attached; or
- b. any Premium for this Rider is not paid before the end of the Grace Period; or
- c. You give Us a written request to end this Rider.

Coverage for an Insured Dependent will end under this Rider when such Insured ceases to be an Eligible Dependent Child or Eligible Spouse, as defined in the Policy.

## PREMIUMS

While this Rider is in force, Premiums are due based on the terms of the Policy to which this Rider is attached.

We reserve the right to change the Premiums for this Rider. When this occurs, the new rate will be guaranteed for a Period of not less than 12 months. We may change the Premiums if:

- a. We change the Premiums for all riders of this same form and issue age in Your state of issue; and
- b. such change complies with the laws and regulations of Your state of issue; and
- c. We give You 45 days written notice before such change becomes effective.

**Other than as stated above, this Rider shall not alter, waive or extend any other provisions of the Policy to which this Rider is attached.**



[Dan George  
President]

# CENTRAL UNITED LIFE INSURANCE

Home Office: [Little Rock, AR 72201]

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## HOSPITAL INDEMNITY RIDER

Rider Effective Date: \_\_\_\_\_  
(If other than the Policy Effective Date)

### PLEASE READ THIS RIDER CAREFULLY.

This Rider is effective as of the Policy Effective Date unless a different Rider Effective Date is shown above.

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of the application and receipt of the first Premium. All Definitions, Provisions, Limitations and Exceptions of the Policy apply to this Rider, except as modified by this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

### DEFINITIONS

**Injury/Injured:** Bodily injuries sustained which:

- a. are directly caused by an accident, independent and unrelated of all other causes; and
- b. have not been specifically excluded by name or description in the Policy or this Rider; and
- c. are not caused or contributed to by Sickness; and
- d. occur while this Rider is in force for the Insured.

Losses that occur after the Pre-Existing Condition provision has been satisfied will be covered for an Injury that occurred before the date the person becomes an Insured under this Rider unless the Injury has been specifically excluded by name or description within the Policy or Rider.

**Period of Confinement:** One continuous Hospital Confinement or several Hospital Confinements for the same or a related cause, which are separated by less than 60 days. Each Hospital Confinement must begin while this Rider is in force for the Insured.

**Sickness:** Disease or illness, including pregnancy, which: (1) is diagnosed or treated while this Rider is in force for the Insured; and (2) does not result from Pre-Existing Conditions as defined; and (3) has not been specifically excluded by name or description in the Policy or this Rider.

### BENEFITS

For the Hospital Indemnity Benefit Amount to be payable, the Hospital Confinement must:

- a. begin while this Rider is in force for the Insured; and
- b. be at the direction of and under the supervision of a Physician; and
- c. be for treatment of an Injury or Sickness.

The Benefit Amount is the amount shown on the Policy Schedule of the Policy to which this Rider is attached. The maximum number of days that We will pay during a Period of Confinement is 365.

### TERMINATION

This Rider ends on the earlier of the date:

- a. Your coverage terminates under the Policy to which this Rider is attached; or
- b. any Premium for this Rider is not paid before the end of the Grace Period; or
- c. You give Us a written request to end this Rider.

Coverage for an Insured Dependent will end under this Rider when such Insured ceases to be an Eligible Dependent Child or Eligible Spouse, as defined in the Policy.

## PREMIUMS

While this Rider is in force, Premiums are due based on the terms of the Policy to which this Rider is attached.

We reserve the right to change the Premiums for this Rider. When this occurs, the new rate will be guaranteed for a period of not less than 12 months. We may change the Premiums if:

- a. We change the Premiums for all riders of this same form and issue age in Your state of issue; and
- b. such change complies with the laws and regulations of Your state of issue; and
- c. We give You 45 days written notice before such change becomes effective.

**Other than as stated above, this Rider shall not alter, waive or extend any other provisions of the Policy to which this Rider is attached.**



[Dan George  
President]

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## SPECIFIED INJURY RIDER

Rider Effective Date: \_\_\_\_\_  
(If other than the Policy Effective Date)

### PLEASE READ THIS RIDER CAREFULLY.

This Rider is effective as of the Policy Effective Date unless a different Rider Effective Date is shown above.

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of the application and receipt of the first Premium. All Definitions, Provisions, Limitations and Exceptions of the Policy apply to this Rider except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

### DEFINITIONS

**Anesthesia:** Anesthesia includes local and general anesthesia.

**Injury/Injured:** Bodily injuries sustained which:

- a. are directly caused by an accident, independent and unrelated of all other causes; and
- b. have not been specifically excluded by name or description in the Policy or this Rider; and
- c. are not caused or contributed to by Sickness; and
- d. occur while this Rider is in force for the Insured.

Losses that occur after the Pre-Existing Condition provision has been satisfied will be covered for an Injury that occurred before the date the person becomes an Insured under this Rider unless the Injury has been specifically excluded by name or description within the Policy or Rider.

### BENEFITS

#### APPLIANCE:

We will pay this Benefit if an Insured is Injured and is required to use an appliance as a result of the Injury. The appliance must be used to help the Insured move around and not be used for treatment of the Injury. Dental appliances or orthodontia will not be covered. A Physician must advise the use of an appliance, and the Insured must begin using it within 90 days after the Injury. After all of these things occur, We will pay this Benefit for each Injury.

**\$ 25.00**

#### AMBULANCE:

We will pay this Benefit if an Insured is Injured and requires transportation to a Hospital. The Insured must be transported by a professional ambulance service within 90 days after the Injury. After all of these things occur, We will pay this Benefit for each Injury.

**\$ 25.00**

#### BLOOD/PLASMA:

We will pay this Benefit if an Insured is Injured and requires blood/plasma. The Insured must receive the blood/plasma within 90 days after the Injury. After all of these things occur, We will pay this Benefit for each Injury.

**\$50.00**

#### BURNS:

We will pay this Benefit if an Insured receives burns in an Injury. The burns must be second degree burns that cover at least thirty-six percent of the body surface or third degree burns that cover at least nine square inches of the body surface. A Physician must treat the Insured within 72 hours after the Injury. After all of these things occur, We will pay this Benefit for each Injury.

**\$600.00**

## **DISLOCATION (SEPARATED JOINT):**

We will pay this Benefit if an Insured receives a dislocation due to an Injury. A dislocation is a completely separated joint. A Physician must diagnose it as a dislocation within 90 days after the Injury. The dislocation must require correction by a Physician with the use of Anesthesia. It can be corrected by open or closed reduction. After all of these things occur, We will pay the Benefit shown in the schedule below for the joint involved. If the dislocation is not listed, We will pay a Benefit most comparable to what is listed for a dislocation in the schedule.

If an Insured receives more than one dislocation in an Injury, and they require open or closed reduction We will pay no more than one and one-half times the Benefit for the joint involved which has the highest benefit amount.

If the dislocation requires reduction by a Physician without the use of Anesthesia, We will pay twenty-five percent of the Benefit shown for the joint involved.

If a Physician diagnoses the dislocation as an incomplete dislocation, We will pay twenty-five percent of the Benefit shown for the joint involved. An incomplete dislocation is a dislocation in which the joint is not completely separated.

If an Insured receives a fracture and a dislocation in the same Injury, We will pay for both. However, We will pay no more than one and one-half times the Benefit for the bone or joint involved which has the highest benefit amount.

<b>Joint</b>	<b>Insured</b>	<b>Spouse</b>	<b>Children</b>
<b>Hip</b>	\$1,500.00	\$1,000.00	\$450.00
<b>Knee (except Patella)</b>	\$1,100.00	\$750.00	\$325.00
<b>Shoulder</b>			
<b>Glenohumeral</b>	\$800.00	\$550.00	\$225.00
<b>Collar Bone</b>			
<b>Sternoclavicular</b>	\$800.00	\$550.00	\$225.00
<b>Acromioclavicular</b>	\$720.00	\$480.00	\$225.00
<b>Acromioclavicular Separation</b>	\$720.00	\$480.00	\$225.00
<b>Ankle – Bone or Bones of the Foot (other than toes)</b>	\$660.00	\$440.00	\$200.00
<b>Bone or Bones of the Hand (Other than Fingers)</b>	\$600.00	\$400.00	\$175.00
<b>Lower Jaw</b>	\$500.00	\$350.00	\$150.00
<b>Wrist</b>	\$450.00	\$300.00	\$125.00
<b>Elbow</b>	\$325.00	\$225.00	\$100.00
<b>One Toe or Finger</b>	\$150.00	\$100.00	\$40.00

## **EYE INJURY:**

We will pay this Benefit if an Insured receives an eye Injury. It must require surgery with Anesthesia. An exam with Anesthesia will not be considered surgery. A Physician must perform the surgery within 90 days after the Injury. After all of these things occur, We will pay this Benefit for each Injury.

**\$100.00**

## **FRACTURE (BROKEN BONE):**

We will pay this Benefit if an Insured receives a fracture in an Injury. A fracture is a break in a bone, which can be seen by x-ray. A Physician must diagnose it as a fracture within 90 days after the Injury. The fracture must require correction by a Physician. It can be corrected by open or closed reduction. After all of these things occur, We will pay the Benefit shown in the schedule below for the bone involved. If the fracture is not listed, We will pay a Benefit most comparable to what is listed for a fracture in the schedule.

If an Insured receives more than one fractured bone in an Injury, and they require open or closed reduction We will pay no more than one and one-half times the Benefit for the bone involved which has the highest benefit amount.

If a Physician diagnoses the fracture as a chip fracture, We will pay ten percent of the Benefit shown for the bone involved.

If the Insured receives a fracture and a dislocation in the same Injury, We will pay for both. However, We will pay no more than one and one-half times the Benefit for the bone or joint involved which has the highest benefit amount.

<b>Bone</b>	<b>Insured</b>	<b>Spouse</b>	<b>Children</b>
<b>Hip, Thigh</b> (Femur)	\$1,800.00	\$1,200.00	\$500.00
<b>Vertebrae, Body of</b> (except Vertebral Processes)	\$1,600.00	\$1,000.00	\$450.00
<b>Pelvis</b> (includes Ilium, Ischium, Pubis Acetabulum except Coccyx)	\$1,400.00	\$950.00	\$375.00
<b>Skull</b> (except Bones of the Face or Nose)			
<b>Simple Non- Reduction Skull Fracture</b>	\$600.00	\$400.00	\$175.00
<b>Depressed Skull Fracture</b>	\$1,350.00	\$900.00	\$375.00
<b>Leg</b> ( Tibia and/or Fibula)	\$1,100.00	\$750.00	\$300.00
<b>Forearm</b> ( Radius and/or Ulna)			
<b>Hand or Wrist</b> (except Finger)	\$900.00	\$600.00	\$250.00
<b>Foot</b> (except Toes), <b>Ankle, Kneecap</b> (Patella)	\$900.00	\$600.00	\$250.00
<b>Lower Jaw, Mandible</b> (except Alveolar Process)	\$720.00	\$480.00	\$200.00
<b>Shoulder Blade</b> (Scapula), <b>Collar Bone</b> (Clavicle, Sternum)	\$720.00	\$480.00	\$200.00
<b>Arm, between Elbow and Shoulder</b> (Humerus)	\$630.00	\$420.00	\$175.00
<b>Upper Jaw. Maxilla</b> (except Alveolar Process)	\$630.00	\$420.00	\$175.00
<b>Bones of Face or Nose</b> (except Mandible or Maxilla)	\$550.00	\$375.00	\$150.00
<b>Vertebral Processes</b> – Transverse, Spinous, etc.	\$350.00	\$250.00	\$100.00
<b>Coccyx, One Rib, Finger, Toe</b>	\$150.00	\$100.00	\$40.00

#### **RUPTURED DISK:**

We will pay this Benefit if an Insured receives a ruptured disk in an Injury. A Physician must treat it within 90 days after the Injury. A Physician must repair it with surgery within one year after the Injury. After all of these things occur, We will pay one of these Benefits for each Injury. The Benefit We will pay will be based on when the Injury occurs.

Injury which occurs less than one year after the Effective Date of this Rider	<b>\$100.00</b>
Injury which occurs one year or more after the Effective Date of this Rider	<b>\$400.00</b>

#### **TENDON/LIGAMENT:**

We will pay this Benefit if an Insured receives an Injury to a tendon/ligament. It must be torn, ruptured or severed. A Physician must repair it with surgery within 90 days after the Injury. After all of these things occur, We will pay one of these Benefits for each Injury. The Benefit We pay will be based on the number of tendons/ligaments repaired as the result of each Injury.

Repair of one tendon or ligament	<b>\$500.00</b>
Repair of all tendons/ligaments if more than one	<b>\$750.00</b>

If the Insured is Injured and receives a fracture or a dislocation and tears, ruptures or severs a tendon/ligament, We will pay only one Benefit. We will pay the largest of the appropriate Tendon/Ligament Benefit, the Fracture Benefit or the Dislocation Benefit.

#### **TORN KNEE CARTILAGE:**

We will pay this Benefit if an Insured receives a torn knee cartilage (meniscus) in an Injury. A Physician must treat it within 90 days after the Injury. A Physician must repair it with surgery within one year after the Injury. After all of these things occur, We will pay one of these Benefits for each Injury. The Benefit We pay will be based on when the Injury occurs.

Injury which occurs less than one year after the Effective Date of this Rider	<b>\$100.00</b>
Injury which occurs one year or more after the Effective Date of this Rider	<b>\$400.00</b>

#### **GUNSHOT WOUND:**

**There are no Gunshot Wound benefits for Insured Dependents.**

We will pay this Benefit if You are Injured by a gunshot wound and You did not intentionally shoot Yourself. It must be caused by a projectile from a conventional firearm. A conventional firearm is a weapon which fires a projectile (bullet) by gun powder or compressed gas. It must require treatment by a Physician, including a Hospital Confinement, within 24 hours and surgery within 72 hours after the Injury. After all of these things occur, We will pay this Benefit for each Injury.

**\$1,000.00**



If You are shot more than once in a 24-hour period, We will pay Benefits only for the first wound.

If You receive a fracture or a dislocation as the result of the same gunshot wound accident, We will pay the Benefit shown above for the Gunshot Wound Benefit plus one-half the Fracture Benefit or the Dislocation Benefit shown in this Rider for the bone or joint involved. However, We will not pay more than \$2,000 total for each Injury involving a combination of a gunshot wound with a fracture or a dislocation.

### **LIMITATIONS AND EXCLUSIONS**

For this Rider, the following are added to Part I of Limitations and Exclusions contained in the Policy:

- a. riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
- b. driving a car or any other licensed vehicle on a highway without a valid operator's license; or
- c. mountaineering, sky diving, hang gliding or bungee jumping; or
- d. Insured Dependent(s) practicing for or participating in any high school, college, semi-professional or professional competitive athletic contest. This does not apply to intramural sports.

Sickness is not covered under this Rider.

### **TERMINATION**

This Rider ends on the earlier of the date:

- a. Your coverage terminates under the Policy to which this Rider is attached; or
- b. any Premium for this Rider is not paid before the end of the Grace Period; or
- c. You give Us a written request to end this Rider.

Coverage for an Insured Dependent will end under this Rider when such Insured ceases to be an Eligible Dependent Child or Eligible Spouse, as defined in the Policy.

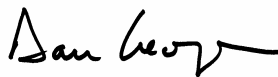
### **PREMIUMS**

While this Rider is in force, Premiums are due based on the terms of the Policy to which this Rider is attached.

We reserve the right to change the Premiums for this Rider. When this occurs, the new rate will be guaranteed for a period of not less than 12 months. We may change the Premiums if:

- a. We change the Premiums for all riders of this same form and issue age in Your state of issue; and
- b. such change complies with the laws and regulations of Your state of issue; and
- c. We give You 45 days written notice before such change becomes effective.

**Other than as stated above, this Rider will not alter any other provision of the Policy to which this Rider is attached.**



[Dan George  
President]

# CENTRAL UNITED LIFE INSURANCE COMPANY

Home Office: [Little Rock, AR 72201]

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## FIRST HOSPITAL CONFINEMENT RIDER

Rider Effective Date: \_\_\_\_\_  
(If other than the Policy Effective Date)

### PLEASE READ THIS RIDER CAREFULLY.

This Rider is effective as of the Policy Effective Date unless a different Rider Effective Date is shown above.

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of the application and receipt of the first Premium. All Definitions, Provisions, Limitations and Exceptions of the Policy apply to this Rider, except as modified by this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

### DEFINITIONS

**Calendar Year:** The period starting on the Policy Effective Date and ending on December 31 of the same year. From then on, it is the period starting on January 1 and ending on December 31.

**First Hospital Confinement:** The first Period of Confinement in a Calendar Year for an Insured. No other Period of Confinement during a Calendar Year will be considered a First Hospital Confinement.

**Injury/Injured:** Bodily injuries sustained which:

- a. are directly caused by an accident, independent and unrelated of all other causes; and
- b. have not been specifically excluded by name or description in the Policy or this Rider; and
- c. are not caused or contributed to by Sickness; and
- d. occur while this Rider is in force for the Insured.

Losses that occur after the Pre-Existing Condition provision has been satisfied will be covered for an Injury that occurred before the date the person becomes an Insured under this Rider unless the Injury has been specifically excluded by name or description within the Policy or Rider.

**Period of Confinement:** One continuous Hospital Confinement or several Hospital Confinements for the same or a related cause, which are separated by less than 60 days. Each Hospital Confinement must begin while this Rider is in force for the Insured.

**Sickness:** Disease or illness, including pregnancy, which: (1) is diagnosed or treated while this Rider is in force for the Insured; and (2) does not result from Pre-Existing Conditions as defined; and (3) has not been specifically excluded by name or description in the Policy or this Rider.

### BENEFITS

We will pay the Benefit Amount for an Insured's First Hospital Confinement. Before Benefits are payable, the Hospital Confinement must:

- a. be due to Injury or Sickness; and
- b. begin while this Rider is in force for the Insured; and
- c. be at the direction of and under the supervision of a Physician.

The Benefit Amount is listed on the Schedule in this Rider. The Benefit Amount will be the amount next to the total number of days of Hospital Confinement during the Period of Confinement. Benefits for this Rider will be limited to the First Hospital Confinement each Calendar Year for each Insured. The Benefit Amount is not a cumulative benefit and will not exceed \$5,000 for each Insured for each Calendar Year.

## SCHEDULE

<u>Total Days of Hospital Confinement</u>	<u>Benefit Amount</u>
One	\$500.00
Two	\$1,000.00
Three	\$2,000.00
Four	\$3,000.00
Five	\$4,000.00
Six	\$5,000.00

## TERMINATION

This Rider ends on the earlier of the date:

- a. Your coverage terminates under the Policy to which this Rider is attached; or
- b. any Premium for this Rider is not paid before the end of the Grace Period; or
- c. You give Us a written request to end this Rider.

Coverage for an Insured Dependent will end under this Rider when such Insured ceases to be an Eligible Dependent Child or Eligible Spouse, as defined in the Policy.

## PREMIUMS

While this Rider is in force, Premiums are due based on the terms of the Policy to which this Rider is attached.

We reserve the right to change the Premiums for this Rider. When this occurs, the new rate will be guaranteed for a period of not less than 12 months. We may change the Premiums if:

- a. We change the Premiums for all riders of this same form and issue age in Your state of issue; and
- b. such change complies with the laws and regulations of Your state of issue; and
- c. We give You 45 days written notice before such change becomes effective.

**Other than as stated above, this Rider shall not alter, waive or extend any other provisions of the Policy to which this Rider is attached.**



[Dan George  
President]

**CENTRAL UNITED LIFE INSURANCE**

*Home Office: [Little Rock, AR 72201]*

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**AMENDMENT/ENDORSEMENT**

Policy No: XXXXXXXXXX

NAME:

[INFORMATION]

In Witness Whereof, CENTRAL UNITED LIFE INSURANCE COMPANY has issued this Endorsement/Amendment on the effective date of the Policy unless otherwise specified above.

A handwritten signature in black ink, appearing to read "Dan George", with a stylized flourish at the end.

[Dan George  
President]

**CENTRAL UNITED LIFE INSURANCE**

*Home Office: [Little Rock, AR 72201]*

*Administrative Office: [10700 Northwest Freeway Houston, TX 77092] [800-669-9030]*

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**AMENDMENT/ENDORSEMENT**

Policy No: XXXXXXXXXX

NAME:

[INFORMATION]

I hereby agree that these changes will be an Endorsement/Amendment to and becoming a part of the Policy/Application to which it is attached. This Endorsement/Amendment will not change, alter or amend the Policy or Rider to which it is attached in any way except as expressly stated herein.

Dated this \_\_\_\_\_ Day of \_\_\_\_\_ 20 \_\_\_\_\_

Witness \_\_\_\_\_ Signed \_\_\_\_\_  
(To be signed by witness) (To be signed by owner)



[Dan George  
President]

SERFF Tracking Number: EWLE-126902630 State: Arkansas  
Filing Company: Central United Life Insurance Company State Tracking Number: 47310  
Company Tracking Number:  
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other  
Product Name: Disability Income  
Project Name/Number: /

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 11/22/2010	Disability Income Policy, Building Benefit Rider, Emergency Accident Rider, Outpatient Sickness Rider, Accidental Death & Dismemberment Rider, Hospital Injury Indemnity Rider, Hospital Indemnity Rider, Specified Injury Rider, First Hospital Confinement Rider	CDI10-AR, CDI- BBR10, CDI- EAR10, CDI- OSR10, CDI- ADD10, CDI- HINJ10, CDI- HIR10, CDI- SIR10, CDI- HCR10	New		CULICCDI10RatesOnly10-23-10Generic.pdf

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Premiums****Disability Income - Accident Only**  
**No Benefits Payable if WC Payable**

Monthly Premium per \$100 Monthly Benefit

<u>Occupational Class I</u>					<u>Occupational Class II</u>				
Benefit Period					Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years	Elimination Period	90 days	6 months	1 year	2 years
0 days	0.90	1.00	1.25	1.75	0 days	1.80	2.05	2.30	3.20
7 days	0.80	0.85	1.10	1.55	7 days	1.60	1.80	2.15	2.90
14 days	0.65	0.75	1.00	1.45	14 days	1.35	1.50	1.90	2.65
30 days	0.45	0.55	0.80	1.15	30 days	1.05	1.20	1.55	2.15
60 days	0.35	0.40	0.55	0.90	60 days	0.65	0.85	1.15	1.65
90 days	NA	0.30	0.45	0.80	90 days	NA	0.70	0.95	1.45
180 days	NA	NA	0.15	0.40	180 days	NA	NA	0.45	0.90
365 days	NA	NA	NA	0.35	365 days	NA	NA	NA	0.60

<u>Occupational Class III</u>				
Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years
0 days	1.80	2.05	2.30	3.20
7 days	1.60	1.80	2.15	2.90
14 days	1.35	1.50	1.90	2.65
30 days	1.05	1.20	1.55	2.15
60 days	0.65	0.85	1.15	1.65
90 days	NA	0.70	0.95	1.45
180 days	NA	NA	0.45	0.90
365 days	NA	NA	NA	0.60

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Premiums****Disability Income - Accident Only**  
**50% Benefits Payable if WC Payable**

Monthly Premium per \$100 Monthly Benefit

<u>Occupational Class I</u>					<u>Occupational Class II</u>				
Benefit Period					Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years	Elimination Period	90 days	6 months	1 year	2 years
0 days	1.10	1.20	1.50	2.10	0 days	2.25	2.50	2.85	3.90
7 days	0.95	1.00	1.35	1.90	7 days	2.00	2.20	2.60	3.55
14 days	0.80	0.90	1.25	1.75	14 days	1.75	1.90	2.35	3.25
30 days	0.60	0.70	0.95	1.40	30 days	1.35	1.50	1.90	2.65
60 days	0.45	0.50	0.65	1.10	60 days	0.80	1.05	1.40	2.05
90 days	NA	0.35	0.60	0.90	90 days	NA	0.85	1.15	1.75
180 days	NA	NA	0.25	0.50	180 days	NA	NA	0.55	1.05
365 days	NA	NA	NA	0.45	365 days	NA	NA	NA	0.80

<u>Occupational Class III</u>				
Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years
0 days	2.25	2.50	2.85	3.90
7 days	2.00	2.20	2.60	3.55
14 days	1.75	1.90	2.35	3.25
30 days	1.35	1.50	1.90	2.65
60 days	0.80	1.05	1.40	2.05
90 days	NA	0.85	1.15	1.75
180 days	NA	NA	0.55	1.05
365 days	NA	NA	NA	0.80



**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Premiums****Disability Income - Accident Only**  
**100% Benefits Payable if WC Payable**

Monthly Premium per \$100 Monthly Benefit

<u>Occupational Class I</u>					<u>Occupational Class II</u>				
Benefit Period					Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years	Elimination Period	90 days	6 months	1 year	2 years
0 days	1.30	1.40	1.75	2.45	0 days	2.55	2.90	3.35	4.60
7 days	1.15	1.20	1.55	2.20	7 days	2.40	2.60	3.00	4.20
14 days	0.95	1.05	1.45	2.05	14 days	2.15	2.30	2.75	3.85
30 days	0.70	0.80	1.10	1.65	30 days	1.65	1.80	2.25	3.20
60 days	0.55	0.60	0.80	1.25	60 days	1.00	1.20	1.65	2.45
90 days	NA	0.45	0.70	1.10	90 days	NA	1.00	1.35	2.10
180 days	NA	NA	0.25	0.55	180 days	NA	NA	0.65	1.40
365 days	NA	NA	NA	0.50	365 days	NA	NA	NA	1.05

<u>Occupational Class III</u>				
Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years
0 days	2.55	2.90	3.35	4.60
7 days	2.40	2.60	3.00	4.20
14 days	2.15	2.30	2.75	3.85
30 days	1.65	1.80	2.25	3.20
60 days	1.00	1.20	1.65	2.45
90 days	NA	1.00	1.35	2.10
180 days	NA	NA	0.65	1.40
365 days	NA	NA	NA	1.05

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10** (and associated riders)  
**Premiums**

**Disability Income - Sickness Only**

Monthly Premium per \$100 Monthly Benefit

<u>Occupational Class I</u>					<u>Occupational Class II</u>				
Benefit Period					Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years	Elimination Period	90 days	6 months	1 year	2 years
7 days	2.84	3.41	4.29	6.83	7 days	2.98	3.58	4.50	7.17
14 days	2.47	3.05	3.91	6.24	14 days	2.59	3.20	4.10	6.55
30 days	1.79	2.26	3.03	5.07	30 days	1.87	2.37	3.18	5.32
60 days	1.10	1.47	2.09	3.45	60 days	1.16	1.54	2.19	3.62
90 days	NA	1.16	1.71	2.93	90 days	NA	1.21	1.79	3.07
180 days	NA	NA	1.02	1.76	180 days	NA	NA	1.07	2.18
365 days	NA	NA	NA	1.43	365 days	NA	NA	NA	1.73

<u>Occupational Class III</u>				
Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years
7 days	3.13	3.76	4.73	7.52
14 days	2.72	3.36	4.31	6.88
30 days	1.97	2.49	3.34	5.59
60 days	1.22	1.62	2.30	3.80
90 days	NA	1.27	1.88	3.22
180 days	NA	NA	1.13	2.29
365 days	NA	NA	NA	1.82

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Premiums**

**Accidental Death &  
Dismemberment Rider**

Monthly Premiums

Issue			
Age	Insured	Spouse	Children
All	0.10	0.10	0.10

**Emergency Accident Rider**

Monthly Premiums

Issue			
Age	Insured	Spouse	Children
All	0.57	0.57	0.57

**Hospital Indemnity Rider**

Monthly Premiums

Issue			
Age	Insured	Spouse	Children
All	1.25	1.25	0.75

**Hospital Injury Indemnity Rider**

Monthly Premiums

Issue			
Age	Insured	Spouse	Children
All	0.20	0.20	0.15

**Voluntary Individual Disability Income Product  
Policy Form – CDI10 (and associated riders)  
Premiums**

**Outpatient Sickness Rider**

Monthly Premiums

Issue			
Age	Insured	Spouse	Children
All	3.65	3.65	6.00

**Specified Injury Rider**

Monthly Premiums

Issue			
Age	Insured	Spouse	Children
All	3.50	3.50	1.75

**First Hospital Confinement Rider**

Monthly Premiums

Issue			
Age	Insured	Spouse	Children
0-49	22.50	12.50	8.00
50-59	25.00	20.00	8.00
60+	50.00	30.00	8.00

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Premiums****Building Benefit Rider - Accident Only**  
**No Benefits Payable if WC Payable**

Monthly Premium per \$100 Monthly Benefit

<u>Occupational Class I</u>					<u>Occupational Class II</u>				
Benefit Period					Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years	Elimination Period	90 days	6 months	1 year	2 years
0 days	NA	0.02	0.02	0.03	0 days	NA	0.04	0.04	0.05
7 days	NA	0.02	0.02	0.02	7 days	NA	0.03	0.04	0.04
14 days	NA	0.01	0.02	0.02	14 days	NA	0.03	0.03	0.04
30 days	NA	0.01	0.01	0.02	30 days	NA	0.02	0.02	0.03
60 days	NA	0.01	0.01	0.01	60 days	NA	0.01	0.02	0.02
90 days	NA	0.01	0.01	0.01	90 days	NA	0.01	0.01	0.02
180 days	NA	NA	0.01	0.01	180 days	NA	NA	0.01	0.01
365 days	NA	NA	NA	0.01	365 days	NA	NA	NA	0.01

<u>Occupational Class III</u>				
Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years
0 days	NA	0.04	0.04	0.05
7 days	NA	0.03	0.04	0.04
14 days	NA	0.03	0.03	0.04
30 days	NA	0.02	0.02	0.03
60 days	NA	0.01	0.02	0.02
90 days	NA	0.01	0.01	0.02
180 days	NA	NA	0.01	0.01
365 days	NA	NA	NA	0.01

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Premiums****Building Benefit Rider - Accident Only**  
**50% Benefits Payable if WC Payable**

Monthly Premium per \$100 Monthly Benefit

<u>Occupational Class I</u>					<u>Occupational Class II</u>				
Benefit Period					Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years	Elimination Period	90 days	6 months	1 year	2 years
0 days	NA	0.02	0.02	0.05	0 days	NA	0.05	0.05	0.05
7 days	NA	0.02	0.02	0.04	7 days	NA	0.04	0.04	0.04
14 days	NA	0.01	0.02	0.04	14 days	NA	0.04	0.04	0.04
30 days	NA	0.01	0.01	0.03	30 days	NA	0.04	0.03	0.03
60 days	NA	0.01	0.01	0.02	60 days	NA	0.02	0.02	0.02
90 days	NA	0.01	0.01	0.02	90 days	NA	0.02	0.02	0.02
180 days	NA	NA	0.01	0.02	180 days	NA	NA	0.02	0.02
365 days	NA	NA	NA	0.02	365 days	NA	NA	NA	0.02

<u>Occupational Class III</u>				
Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years
0 days	NA	0.05	0.05	0.05
7 days	NA	0.04	0.04	0.04
14 days	NA	0.04	0.04	0.04
30 days	NA	0.04	0.03	0.03
60 days	NA	0.02	0.02	0.02
90 days	NA	0.02	0.02	0.02
180 days	NA	NA	0.02	0.02
365 days	NA	NA	NA	0.02

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Premiums****Building Benefit Rider - Accident Only**  
**100% Benefits Payable if WC Payable**

Monthly Premium per \$100 Monthly Benefit

<u>Occupational Class I</u>					<u>Occupational Class II</u>				
Benefit Period					Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years	Elimination Period	90 days	6 months	1 year	2 years
0 days	NA	0.03	0.04	0.05	0 days	NA	0.06	0.07	0.09
7 days	NA	0.02	0.03	0.04	7 days	NA	0.05	0.06	0.08
14 days	NA	0.02	0.03	0.04	14 days	NA	0.05	0.06	0.08
30 days	NA	0.02	0.02	0.03	30 days	NA	0.04	0.05	0.06
60 days	NA	0.01	0.02	0.03	60 days	NA	0.02	0.03	0.05
90 days	NA	0.01	0.01	0.02	90 days	NA	0.02	0.03	0.04
180 days	NA	NA	0.01	0.01	180 days	NA	NA	0.02	0.03
365 days	NA	NA	NA	0.01	365 days	NA	NA	NA	0.02

<u>Occupational Class III</u>				
Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years
0 days	NA	0.06	0.07	0.09
7 days	NA	0.05	0.06	0.08
14 days	NA	0.05	0.06	0.08
30 days	NA	0.04	0.05	0.06
60 days	NA	0.02	0.03	0.05
90 days	NA	0.02	0.03	0.04
180 days	NA	NA	0.02	0.03
365 days	NA	NA	NA	0.02

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10** (and associated riders)  
**Premiums**

**Building Benefit Rider - Sickness Only**

Monthly Premium per \$100 Monthly Benefit

<u>Occupational Class I</u>					<u>Occupational Class II</u>				
Benefit Period					Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years	Elimination Period	90 days	6 months	1 year	2 years
7 days	NA	0.07	0.08	0.11	7 days	NA	0.04	0.05	0.08
14 days	NA	0.06	0.07	0.10	14 days	NA	0.03	0.04	0.06
30 days	NA	0.04	0.06	0.08	30 days	NA	0.02	0.03	0.05
60 days	NA	0.03	0.04	0.05	60 days	NA	0.02	0.02	0.04
90 days	NA	0.02	0.03	0.05	90 days	NA	0.02	0.02	0.03
180 days	NA	NA	0.02	0.03	180 days	NA	NA	0.02	0.02
365 days	NA	NA	NA	0.02	365 days	NA	NA	NA	0.02

<u>Occupational Class III</u>				
Benefit Period				
Elimination Period	90 days	6 months	1 year	2 years
7 days	NA	0.04	0.05	0.08
14 days	NA	0.03	0.04	0.06
30 days	NA	0.02	0.03	0.05
60 days	NA	0.02	0.02	0.04
90 days	NA	0.02	0.02	0.03
180 days	NA	NA	0.02	0.02
365 days	NA	NA	NA	0.02



**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Occupational Factors**

<b>Industry Description</b>	<b>Industry Class</b>
Accounting Firms, Auditing and Bookkeeping	1
Adult Entertainment	Ineligible
Advertising--Constructing, erecting, painting and maintaining outdoor billboards and displays	2
Advertising--Consulting and Ad preparation	1
Aeronautical Engineering	1
Agricultural Chemicals/Adhesives Manufacturing	3
Agricultural Production and Related Ag Services--Including crop, dairy, livestock and chicken farms. Proprietor (Supervising Only)	3
Air Conditioning/Heating Companies--Dealers	1
Air Conditioning/Heating Companies--Installers	1
Air Transportation-Nonscheduled	3
Air Transportation-Scheduled	3
Aircraft Manufacturing	1
Airport Terminals (No flight crews)	2
Alterations Shop	1
Aluminum Recycling Centers Does not include salvage yards	1
Ambulance Service Companies	1
Ammunition and Explosives Manufacturing	Ineligible
Amusement and Recreation	Ineligible
Amusement Park Equipment Manufacturing	1
Amusement Parks	3
Answering Services	1
Apartment Management With maintenance services	2
Apartment Management Without maintenance services	1
Apparel and Other Textile Products	1
Appliances Sales and Service	1
Architectural Firms	1
Armature/Rewinding Companies	2
Art Galleries	1
Art Supply Stores	1
Asbestos Products	Ineligible
Asphalt Paving Contractors	3
Asphalt Refineries	2

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Occupational Factors**

<b>Industry Description</b>	<b>Industry Class</b>
Associations-Employee or Professional	3
Athletic Teams	Ineligible
Auto Body Shops	2
Auto Dealer Leasing	1
Auto Dealer-New Cars & Used	1
Auto Detail Shops	2
Auto Parts-Used	2
Auto Repair Services, Parking	2
Auto Towing Services	2
Auto Upholsterers and Vinyl Top Installation	2
Auto Vehicle Rental	1
Auto-Customizing-Designing and Converting	2
Automobile Parts Sales-Retail/Wholesale	1
Awning Installation	2
Babysitting Services	Ineligible
Bakeries	1
Bands and Orchestras	Ineligible
Banks	1
Barber/Beauty Shops-No 1099 employees	3
Bars, Taverns, Nightclubs	Ineligible
Battery Manufacturing	2
Beer and Wine Wholesale Distributors	1
Bingo Establishments	3
Blankbooks and Bookbinding Companies Manufacturing or Retail	1
Blueprinting Services	1
Book Stores	1
Bottled Gas Dealers	1
Bottling Companies (Beverages)	1
Bowling Alleys	2
Broadcasting; Radio and TV Studios	1
Building Exterior Cleaning Contractors	3
Building Maintenance Services (Janitorial)	3
Building Supply Companies (Wholesale and Retail)	1
Building Wrecking Companies	3

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Occupational Factors**

<b>Industry Description</b>	<b>Industry Class</b>
Burglar Alarm Sales and Installations	1
Bus Companies-Charter	3
Bus Companies-School	3
Business Machine Sales and Services	1
Cabinetmakers and Installers (Including customized cabinets)	2
Cable TV Companies	2
Camera Stores	1
Camper and Recreational Vehicle Rental	1
Car Washes	3
Carpentry Contractors	3
Carpet and Floor Laying Contractors	3
Carpet Cleaners	2
Carpet Stores -No Installation	1
Casinos and Riverboat Gambling	3
Casket Manufacturing-Metal and Wood	1
Caterers	3
Catering Truck Company	Ineligible
Cellular Phone Companies	1
Cemeteries	2
Chain Saw Sales and Service	1
Chamber of Commerce Employees	1
Charitable Orgs.-United Way, Goodwill, etc.Does not include second hand stores. (Requires prior HO approval)	1
Cleaning/Maintenance/Security/Miscellaneous. Business Services	3
Coal and Ice Dealers	3
Coal, Coke and Wood Manufacturing or Distributors	3
Coating, Galvanizing and Related Services	1
Coin Operated Amusement Centers	3
Colleges and Universities	1
Communication Equipment Manufacturing	1
Computer and Data Processing Services	1
Computer Consulting	1
Computer Programming	1
Computer Retail or Office Equipment Sales and Service	1

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Occupational Factors**

<b>Industry Description</b>	<b>Industry Class</b>
Concrete Contractors	3
Concrete Ready-mix- No installation	1
Construction Companies-Commercial, Residential, Highway, Street, Bridge, Tunnel, etc.	3
Contractors-Building Exterior Cleaning	3
Contractors-Tile, Terrazo and Marble	3
Convenience Stores	Ineligible
Costume Jewelry, Novelties, Buttons, related articles Manufacturing or Retail	1
Cotton Gins	Ineligible
Country Clubs	3
Credit Agencies	1
Credit Union Members	Ineligible
Crop Dusters-Aerial	3
Dairy Products Companies	1
Dance Studios	3
Day Care Centers/Nurseries/Babysitting	2
Delivery Service (Requires Prior Risk Mgmt approval)	1
Dentist Offices and Clinics	1
Department Stores	1
Detective and Protective Agencies	3
Digging and Trenching Companies	3
Dock and Wharf Workers	Ineligible
Doctors Offices and Clinics	1
Domestic Services	Ineligible
Dredging Companies	3
Drug Stores	1
Drugs-Manufacturing	1
Dry Cleaners/Laundries	2
Electric, Gas, Water, etc. (Utilities)	2
Electrical Contractors	2
Electrical Power Generating and Electric Co-ops--Both public and private, power generation transmission, or distribution	1
Electrical/Watch/Jewelry Repair	1

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Occupational Factors**

<b>Industry Description</b>	<b>Industry Class</b>
Electronic Components and Accessories Manufacturing or Retail	1
Electroplating Services	1
Elementary and Secondary Schools	1
Elevator Installation and Service Companies	2
Employment Agencies (Staff Only)	1
Employment Leasing Companies	3
Engineering and Architectural Services	1
EngineeringAeronautical	1
Engravers	1
Equipment Rental/Leasing	1
Exterminating/Disinfecting Companies	1
Fabric Stores	1
Fabricated Metal Products, Except Structural Manufacturing or Retail	1
Fabricated Metal Products, Structural Manufacturing or Retail	2
Facilities Support Services	1
Farm Co-ops	3
Farm Supply & Farm Equipment Stores	1
Farms and Farming Operations	3
Fence Installation	2
Film Processing Labs	1
Fire Departments (Only)	Ineligible
Fire Equipment Supply	1
Fishing, Hunting, Trapping	Ineligible
Food Products except Meat Manufacturing or Retail	1
Foundries	2
Fruit and Vegetable Stands	Ineligible
Fuel Oil Distribution--Retail, wholesale, bulk oil terminals (service stations ineligible)	1
Funeral Homes	2
Furniture and Fixtures Manufacturing or Retail	1
Garage and Overhead Door Installation	3
Gas and Oil Field Services	3
Grain Storage Facilities	1

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Occupational Factors**

<b>Industry Description</b>	<b>Industry Class</b>
GovernmentCity/Municipalities/Counties/Etc: (see below)	Ineligible
Police and Fire Personnel as a % of the eligible employees:	Ineligible
A. None	1
B. Less than 25% of eligible employee/ member population	2
C. 25% or more of eligible employee/member population	3
Health/Beauty Clubs/Spas--No 1099s	3
Hearing Aid Centers	1
Heating and Air Conditioning Sales, Service and Installation	1
Heavy Equipment Repair	2
Home Health Care	3
Hospice	3
Hospitals--General and Psychiatric	Ineligible
Hotels and Motels	3
House Moving Contractors	2
Implement Dealers	1
Industrial Inorganic Chemical Manufacturing	3
Industrial Machinery and Equipment Manufacturing or retail	1
Installation-Glass	2
Installation-Insulations	3
Insurance Carriers	1
Insurance Sales Organizations	1
Ironwork-Ornamental	3
Landscape and Lawn Care	3
Laundries	2
Legal Services	1
Libraries	1
Lighting Fixtures and Supplies	1
Linens Supplies	1
Liquor Stores	3
Logging and Sawmills	Ineligible
Logging Camps and Contractors	Ineligible
Lumber and Construction Materials--Wholesale/Retail	1

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10** (and associated riders)  
**Occupational Factors**

<b>Industry Description</b>	<b>Industry Class</b>
Mailing, Reproduction, Stenographic Services	1
Management and Public Relations	1
Manufacturing--Animal Feed (no slaughtering involved)	1
Manufacturing--Boilers	1
Manufacturing--Brick, Clay, Stone Concrete Products	1
Manufacturing-Broom and Brush	1
Manufacturing--Cabinets	2
Manufacturing--Camper Trailers	1
Manufacturing--Candy and Confectionery Products	1
Manufacturing--Carpet	1
Manufacturing--Charcoal	1
Manufacturing--Chemical and Allied Products--Including soap, cleaning solutions, paints, varnished, lacquers and fertilizers	2
Manufacturing--Clock and Watch Manufacturing	1
Manufacturing--Clothing	1
Manufacturing--Concrete Products	1
Manufacturing--Construction Equipment and Mining Materials	1
Manufacturing--Costume Jewelry, Novelties, Buttons and Related Articles	1
Manufacturing--Cutlery, Hand Tools and General Hardware	1
Manufacturing--Electrical	1
Manufacturing-Farm Machinery	1
Manufacturing-Fertilizers	2
Manufacturing-Fiberglass and Fiberglass Products	2
Manufacturing-Gas	2
Manufacturing-Glass	1
Manufacturing-Hardware	1
Manufacturing-Heating and Solar Panels	1
Manufacturing-Miscellaneous	3
Manufacturing-Mobile Homes	2
Manufacturing-Motor Vehicles and Equipment, Motors, Generators, Welding Apparatus and Industrial Equipment	1
Manufacturing-Oil Field Machinery No Installation	1
Manufacturing--Pens and Pencils	1

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Occupational Factors**

<b>Industry Description</b>	<b>Industry Class</b>
Manufacturing-Plywood	1
Manufacturing-Pottery	1
Manufacturing-Prefab. Buildings and Assemblers	2
Manufacturing-Sewing Machines	1
Manufacturing-Solar Panels and Heating	1
Manufacturing--Tire and Inner Tubes	1
Manufacturing-Tobacco Products	1
Manufacturing-Tool and Die	1
Manufacturing-Toys and Children's Vehicle Manufacturing	1
Manufacturing-Trailer and Campers	1
Manufacturing-Transportation Equipment	1
Manufacturing-Vacuum Cleaners	1
Manufacturing-Wire Products	1
Manufacturing-Wood Building	1
Manufacturing-Wood Products	1
Manufacturing-Wood/Metal	1
Manufacturing--Wood-burning Stove	1
Marine-Boat Building and Repair	2
Marine-Land or in Harbor (Harbormasters)	3
Marine-Marinas	Ineligible
Marine-Shipbuilding and Repairs	3
Masonry	3
Massage Parlors	Ineligible
Meat/Poultry/Eggs/Slaughtering and Rendering Plants	3
Medical Instruments, Photo Equipment, Watches	1
Medical/Dental Labs, Outpatient Clinics	1
Metal and Mineral Wholesale Co.	1
Military Services	Ineligible
Mining/Quarrying--Nonmetallic materials including granite, limestone, and gravel	Ineligible
Mining-Oil and Gas Extraction, Coal and Metal	Ineligible
Motion Picture Theaters	3
Motion Picture/Radio Production and Distribution	1
Moving and Storage Companies	3



**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Occupational Factors**

<b>Industry Description</b>	<b>Industry Class</b>
Museums and Gardens	1
Native American Tribes (Government Administration Only)	1
Police and Fire Personnel as a % of the eligible employees:	
A. None	1
B. Less than 25% of eligible employee/ member population	2
C. 25% or more of eligible employee/member population	3
News Syndicates	1
Newspaper Publishing	1
Nursing Facilities (Convalescent centers, nursing homes)	2
Oil Field and Related Industries--Domestic and offshore	Ineligible
Packing/Crating/Inspection	2
Paints/Organic Chemicals/Ink and Carbon	2
Painting Contractors/Paper Hangers	3
Paper and Allied Products Manufacturing--Includingcardboard box, tube, envelope and bag manufacturing	1
Parking Lots and Related Services	3
Pawn Shops	Ineligible
Pest Control	2
Petroleum Manufacturing	2
Petroleum Wholesale	1
Photofinishing	1
Photography--Engraving, equipment, studios, etc.	1
Pile Driving and Pole Setting Companies	2
Pipelines, Installation and Servicing	3
Planing Mills	2
Plastic and Rubber Materials and Synthetics Manufacturing or Retail	1
Plumbing Sales, Service, or Installation	1
Police Departments (Only)	Ineligible
Pornography--Books, Stores, Peep Shows, etc.	Ineligible
Poultry Processing (One year employment guideline required)	3
Printing Trade Services--Nonmachine work	1
Printing--Commercial/business and greeting cards	1
Private Household Services, Cook, Maids, Chauffeurs, etc.	Ineligible

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Occupational Factors**

<b>Industry Description</b>	<b>Industry Class</b>
Professional Employee Organization (PEO)	3
Publishing Companies	1
Pulp and Paper Mills	2
Quarries-Nonmetallic materials, i.e. Granite, Limestone, Gravel	Ineligible
Railroad Equipment Manufacturing	1
Railroads	Ineligible
Ranches	Ineligible
Real Estate Operators/Lessors	1
Real Estate-No 1099 employees	1
Recycling Companies	1
Religious Organizations	1
Research and Testing Services	1
Restaurant Equipment	1
Restaurant--Management only	3
Restaurants--Fast Food	Ineligible
Retail--Apparel and Accessory Stores	1
Retail--Appliance Sales and Services	1
Retail--Automotive Dealers and Service Stations	1
Retail--Bicycle Sales and Service	2
Retail--Buildingand Garden Supplies	1
Retail--Florist	1
Retail--Food Stores	1
Retail--Miscellaneous	1
Roofing Companies (Off-the-job disability only)	3
Rooming Houses, Camps, Trailer Parks	Ineligible
Salvage Companies	3
Sanitary Services--Including garbage, refuse and sewage systems	3
Savings and Loans Companies (not banks)	1
Seafood Product Plants	2
Seasonal Business	Ineligible
Security Guard	3
Security/Commodity Brokers	1
Septic Tank Companies Manufacturing, Installation, or Servicing	2

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10 (and associated riders)**  
**Occupational Factors**

<b>Industry Description</b>	<b>Industry Class</b>
Service Station Equipment--Installation and Maintenance	2
Service Stations--Including Self Serve	Ineligible
Sheet Metal and Products Fabrication	1
Siding Contractors	3
Smelting, Rolling, Drawing, and Extruding Mills	2
Social Services	2
Speech and Hearing Clinics	1
Sporting Good Stores	1
Steel Erection	3
Steel Forging	2
Steel Foundries	2
Stockyards	3
Structural Steel Fabrication	2
Surveyors	2
Swimming Pool Construction	3
Swimming Pool Maintenance	2
Tanneries and Leather Products Manufacturing	3
Taxi Cab Companies	Ineligible
Telecommunication Sales and Service	1
Telemarketing	Ineligible
Telephone and Power Line Construction Companies (cell tower construction)	3
Telephone Companies (utilities)	2
Television Sales and Service	1
Television/Radio Studios	1
Temporary Agencies (Staff only)	1
Tennis, Handball, and Other Membership Sports Clubs (Staff Only)	1
Textile Mill Products	1
Tire and Battery Dealers--Retail and Wholesale	1
Tire Retreading and Repair Shops (includes vulcanizing)	2
Tobacco Products	1
Towing Companies--Boat towing prohibited	2
Tractor Dealers	1

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10** (and associated riders)  
**Occupational Factors**

<b>Industry Description</b>	<b>Industry Class</b>
Trailer Dealers	1
Transit Authority/Local and Interurban Passenger Trains	3
Transportation Equipment	2
Trash Collection	3
Travel Agencies (No 1099)	1
Tree Surgeons	3
Trophy Manufacturing or Retail	1
Truck Rentals or Leasing	1
Truck Stops	Ineligible
Trucking Companies--No 1099 Employees	3
Truss Manufacturing and Assembly	2
Unions and Labor Organizations (Eligible Industries only)	2
United States Government Allotment	3
United States Postal Service	3
Universities	1
Vacuum Cleaner Sales and Service	1
Vending Machine Companies--Route Sales and Distribution	1
Veterinary Specialties	1
Video Poker Establishments	3
Video Projection Equipment Companies	1
Video Tape Rental	1
Vocational Schools and Educational Services	1
Warehousing Companies	1
Waste Management/Disposal	3
Water Line Construction Companies	3
Water Transportation--Barges, Ferries, etc.	3
Water Well Drilling	3
Weight Control Clinics	1
Welding Shops	2
Wholesale DistributorBeerWine	1
Wholesale Distributors	1
Wholesale--Auto/Furniture/Metal/Electrical/Misc. Durables	1

**Voluntary Individual Disability Income Product**  
**Policy Form – CDI10** (and associated riders)  
**Occupational Factors**

<b>Industry Description</b>	<b>Industry Class</b>
Wholesale--Grocery/Farm/Chemical/Petrol/Beverages	1
Wholesale--Machines/Equipment/Lumber/Plumbing	1
Wholesale--Scrap and Waste Materials	2
Window Cleaning Companies	3
Wine and Cheese Shops	1
Wood Preserving Companies	3
Zoo Employees	3

SERFF Tracking Number:	EWLE-126902630	State:	Arkansas
Filing Company:	Central United Life Insurance Company	State Tracking Number:	47310
Company Tracking Number:			
TOI:	H111 Individual Health - Disability Income	Sub-TOI:	H111.004 Other
Product Name:	Disability Income		
Project Name/Number:	/		

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	11/22/2010
<b>Comments:</b>		
<b>Attachment:</b>		
Readabilitycertificate.pdf		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	11/22/2010
<b>Bypass Reason:</b> Shown on form schedule		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Outline of Coverage	Approved-Closed	11/22/2010
<b>Comments:</b>		
Shown in Form Schedule		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Authorization to File	Approved-Closed	11/22/2010
<b>Comments:</b>		
<b>Attachment:</b>		
Authorization.pdf		

## Readability Certification

Insurance Company: Central United Life Insurance Company

<b><u>Form Number</u></b>	<b><u>Description of Form</u></b>	<b><u>Score</u></b>
CDI10-AR	Disability Income Policy	50.8
CDI-APP10-AR	Application	51.6
CDI-SHQ10	Supplemental Health Questionnaire	55.6
CUL-AAQ	Aviation Activities and Hazardous Activities Questionnaire	50.8
CDI-RAP10-AR	Reinstatement Application	53.9
CReqChg10	Policyholder's Request for Change	57.0
CDI10-OC-AR	Outline of Coverage	52.3
CDI-BBR10	Building Benefit Rider	50.7
CDI-EAR10	Emergency Accident Rider	53.5
CDI-OSR10	Outpatient Sickness Rider	50.7
CDI-ADD10	Accidental Death & Dismemberment Rider	54.2
CDI-HINJ10	Hospital Injury Indemnity Rider	50.6
CDI-HIR10	Hospital Indemnity Rider	51.1
CDI-SIR10	Specified Injury Rider	52.5
CDI-HCR10	First Hospital Confinement Rider	51.0
CDI-AEND10	Amendment/Endorsement	50.4
CDI-AENDS10	Amendment/Endorsement with Signature	50.4

I hereby certify that the above referenced form complies with the readability requirements of this State.



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Authorized Signature

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Mary Lou Rainey

Name

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Secretary

Title

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November 12, 2010

Date

# CENTRAL UNITED

January 1, 2010

Filing Authorization  
Lewis & Ellis, Inc.  
P.O. Box 851857  
Richardson, TX 75085-1857

**RE: Central United Life Insurance Company**

To Whom it May Concern:

We hereby authorize Lewis & Ellis, Inc. to submit state filings of insurance forms/rates/products on behalf of Central United Life Insurance Company.

This authorization includes the power to provide necessary assurances and certifications related to such forms, rates and or products except as prohibited by law.

This authorization is to be effective until revoked in writing by an authorized representative of Central United Life Insurance Company.

Sincerely,

**CENTRAL UNITED LIFE INSURANCE COMPANY**

*Mary Lou Rainey*

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Signature of Company Officer/Representative

